VOL.

I

No. 357

RECORD

SEP 16 1958

JAMES R. BROWNING, Clerk

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15828

ADMINISTRATIVE REVIEW

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY,
Petitioner,

v.

FEDERAL TRADE COMMISSION, *Respondent.*

Petition to Review Decision of the Federal Trade Commission

FILED

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(2)

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

DOCKET NO. 6238

In the Matter of

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY,
a corporation

Complaint

Pursuant to the provisions of the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 and 1015, inclusive), and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that the American Life and Accident Insurance Company, a corporation, hereinafter referred to as respondent, has violated the provisions of said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint stating its charges in that respect as follows:

PARAGRAPH ONE: Respondent American Life and Accident Insurance Company is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of Missouri, with its office and principal place of business located at 3805 Lindell Boulevard, St. Louis 8, Missouri.

PARAGRAPH TWO: Respondent is now, and for more than two years last past has been, engaged as an insurer in the business of insurance in commerce, as "commerce" is defined in the Federal Trade Commission Act, by entering into insurance contracts with insureds located in various States of the United States other than the State of Missouri, in which States the business of insurance is not regulated

by State law to the extent of regulating the practices of respondent alleged in this complaint to be illegal. Respondent maintains, and at all times mentioned herein has maintained, a substantial course of trade in said insurance policies in commerce between and among the several States of the United States.

(3)

Respondent, during the two years last past, has sold insurance coverage contained in a policy, designated by it as "The Provider Individual or Family Group Hospital-Surgical Policy," and sometimes also referred to as "The New Provider Policy," and on occasion as "The American Plan." This Policy is of the type commonly known in the insurance trade and sometimes referred to by respondent as "accident and health policies" or "hospital and surgical policies."

PARAGRAPH THREE: The respondent is licensed to engage in the business of insurance, as heretofore generally described, in the State of Missouri, as provided by the laws of said State. The respondent is not now, and for more than two years last past has not been, licensed, as provided by the respective State laws, to engage in the business of insurance in any State of the United States other than the State of Missouri.

Respondent solicits business by mail in the various States of the United States in addition to the State of Missouri. As a result thereof it has entered into insurance contracts with insureds located in many States in which it is not licensed to do business. Respondent's business practices are not regulated by any of those States as it is not subject to the jurisdiction of such States.

PARAGRAPH FOUR: In the course and conduct of its aforesaid business, respondent during the two years last past, has disseminated or caused the dissemination of advertising in commerce by means of the United States mails, radio broadcasts, and by other means. The said advertisements

contained false, misleading and deceptive statements and

representations concerning the terms and provisions of the contract of insurance as provided by its "New Provider" policy. The purpose and effect of said advertisements was to induce members of the public to become insured by the respondent under the terms and provisions of the aforesaid advertised insurance policy.

PARAGRAPH FIVE: Among and typical, but not all inclusive, of such advertisements, were those disseminated through radio broadcasts over various States of the United States including those broadcast over the States adjacent to and served by Station KMOX, St. Louis, Missouri, which advertisements contained the following statements, among others:

> "As an example, Friends, unlike other Hospitalization plans, this policy pays benefits for hospital room and board for one day, one week, one month or a whole year. Government hospitals, which are usually free are excepted. No waiting 30 or 60 days, it covers you immediately for all accidents and all sickness not requiring surgery . . . sickness requiring surgery covered after policy has been in force six months . . . Benefits for 64 specific surgical operations . . . Benefits for loss of life for travel accident . . . for those who want it a Maternity Rider is available at a small additional charge . . . EXTRA BENEFITS SUCH AS CASH FOR BLOOD TRANSFUSIONS . . . RENTAL OF WHEEL CHAIR OR CRUTCHES . . . OXYGEN, AND AMBULANCE FEES . . . NO DEDUCTION OF BENEFITS ON ACCOUNT OF AGE."

Respondent has also disseminated certain advertisements by means of the United States mails, consisting of circulars, testimonials, form letters and other material which was sent to prospective purchasers of its said policy.

Among the typical of the statements contained in aforesaid circulars, were the following:

"HERE IT IS! One of the most liberal Hospitalization and Accident Insurance plans offered anywhere. It is called the NEW PROVIDER POLICY . . . the features and liberal benefits are available to all from birth to 65 years of age who are in good health. No matter where you live you are eligible for the NEW PROVIDER POLICY. When in need of hospitalization select any hospital and your own doctor. Your NEW PROVIDER POLICY covers you everywhere. . . ."

". . . ALSO PAYS benefits for hospitalization due to sickness, accident or surgery. Full benefits paid to children. To our knowledge, the NEW PROVIDER POLICY is the most liberal yet the lowest priced hospitalization plan now available. Read inside for all the tremendous advantages and cash benefits offered . . . all for only 3¢ a day! . . ."

(5)

". . . NOTE: For those who want it, a Maternity rider is available at small additional charge. Confinement in Government hospitals, or any Institution that is not equipped with a laboratory, operating room, and Registered Nurse, always on duty, are not covered. Sickness resulting in surgery is covered if the cause originates after policy has been in force six months . . ."

"YOU GET $5.00 TO $1,825.00
If sickness strikes and you enter any hospital, you will receive actual expenses and not to exceed $5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year."

"YOU GET $5.00 TO $1,825.00
If accident strikes and you enter any hospital, benefits begin at once. You will receive actual expenses not to exceed $5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year."

"YOU GET $5.00 TO $100.00
For surgical operations you get from $5.00 to $100.00 to help you pay your surgeon while hospitalized. There

are 64 operations listed in the Schedule of Operations."

"... YOU GET $2500.00
THE NEW PROVIDER HOSPITALIZATION POLICY pays your beneficiary in lieu of other benefits $2,500.00 for death as a result of accident while traveling on a common carrier by land, water or air."

The aforesaid circulars were accompanied by various form letters sent from time to time by respondent to prospective policyholders, and in many instances to persons who had already purchased such policy who, in such event, were requested to pass on the literature to others who might be interested in respondent's policy.

Among and typical, but not all inclusive, of the statements contained in said form letters, were the following:

(6)

"... The policy goes into effect immediately, from the first day of hospital confinement for either sickness or accident, except in the case of sickness requiring a surgical operation, then the usual six months waiting period applies.

"In addition, the policy will pay you benefits for 64 surgical operations, as well as benefits for ambulance, blood transfusions, oxygen tent, and rental of wheel chair or crutches. And that is not all: There is also a lump sum benefit $2,500.00 for loss of life due to travel accident by land, water or air."

"There is no reduction in benefits, ever ..."

"Benefits are not reduced because of age; ..."

"We are again enclosing descriptive literature, also calling your attention to a few important facts which you may have overlooked. There is no reduction of benefits for minors or for older persons. The premiums are NOT increased because of age (except in the case of children when they attain age 18) nor is the policy ever cancelled because of age. Hospital room, board and general nursing care benefits are paid for one day and up to one year if you have to stay

that long. Persons up to age of ninety are eligible . . ."

"Send in your application right now, while it is still fresh in your mind. The self-addressed envelope need no postage and you will get your PROVIDER policy within a few days by mail. It will be in full force when the mailman delivers it to you."

In conjunction with the circulars and form letters, as aforesaid, respondent has also sent to prospective policyholders an application for its "New Provider" policy. The said application contained the following statements, among others:

"I hereby apply for a Hospitalization Policy in the American Life and Accident Insurance Company for myself and my dependents, if any, whose names appear below.

"I represent to my best knowledge that all persons named are in good health and that there is no existing condition which may require either Hospitalization or Surgical operation, except as follows: .....

.....

.....

(7)

"I further represent to my best knowledge that all persons named are under 90 years of age (husband or wife), and that all dependent minors are under 18 years of age, and are related to me in the following capacity: husband, wife, son, daughter, stepchildren, legally adopted son or daughter, or legally appointed guardian of minor children."

In many instances where policyholders allowed their policies to lapse through failure to timely remit premiums, respondent has sent various form letters soliciting the restoration of such policies.

Among and typical, but not all inclusive, of the statements contained in said form letters were the following:

". . . If you are still in good health I urge that you put your policy back in force by the payment of only two monthly premiums . . ."

"You may reinstate your expired policy by paying ONLY TWO MONTH'S PREMIUM. You do not have to pay the back premiums. There is no red tape. Just sign the coupon below in the presence of a witness and send it to us with as little as two month's premium and the reinstatement will be promptly acted upon. It is as simple as that—we accept your word that you are in good health."

Certain of said form letters included an application for reinstatement which contained the following statement among others:

"I hereby certify that I am in good health; not now affected by any past or present illness or injury.

Dated ..... this ..... day of

..... 19....

Amount Enclosed

$ .....

.....

Signature

Witness ....."

PARAGRAPH SIX: Through the use of aforesaid statements and representations and others of the same import and meaning, not set out herein, respondent has represented, directly or by implication with respect to said "New Provider" insurance policy:

(8)

1. That the indemnification provided by said policy against loss caused by hospitalization and surgical operations as a result of sickness or accident, can be continually renewed at the option of the insured, regardless of impairment of risk due to the incidence of sickness or accident, in some cases up to 65 years of age and others up to 75 or 90 years of age.

2. That said policy provided up to $100.00 indemnity for surgical expense resulting from each or all of 64 different surgical operations.

3. That the lump sum benefit for loss of life due to travel accident in a common carrier by land, water or air was not otherwise qualified or limited.

4. That the said policy provided indemnification for loss caused by hospitalization or surgical expenses resulting from any or all sicknesses or accidents except:

a. Those existing conditions which, in the opinion of the insured, might require either hospitalization or operation and which were set forth in good faith by the insured in his application for said policy, or for any renewal thereof, and which were subsequently excepted specifically from coverage by indorsement on the policy.

b. Childbirth, unless covered by special rider.

c. Sickness requiring a surgical operation prior to the expiration of six months from the effective date of the policy.

d. Those incurred during service in the armed forces, or treated in Government hospitals, or provided for under Workmen's Compensation Laws.

PARAGRAPH SEVEN: The aforesaid statements and representations were false, misleading and deceptive. In truth and in fact:

1. The indemnification provided by said policy against loss caused by hospitalization and surgical expense as a result of sickness or accident could not be renewed beyond the current premium payment period at the option of the insured, up to age 65, 75 or 90 years of age or any other period of time whatever. On the contrary, said policy was renewable at the option of respondent only and could be

cancelled or terminated at the end of any premium payment period for any reason or for no reason whatever.

(9)

Furthermore, respondent has on many occasions refused to renew said policy in instances where it has determined that the risk involved had become impaired for such reasons as the incidence of sickness or accident.

2. Said policy did not provide $100.00 indemnity for surgical expenses resulting from each or all of 64 different surgical operations. On the contrary, said policy provided a schedule of 64 different operations, and set forth the maximum amount of indemnity for each operation. Of these operations, 60 provided for indemnification in amounts of $50.00 or less, and only one operation, namely cutting into the cranial cavity, provided for indemnification in the amount of $100.00. Furthermore, said policy provided, among other further limitations, that not more than one, the greater, of the amounts specified in said schedule, would be paid on account of any one sickness or for injury resulting from any one accident.

3. Said policy provided said lump sum benefit for loss of life if death of the insured resulted solely from accident or bodily injury within 90 days after such injury, while riding as a fare-paying passenger in any public conveyance, including a licensed passenger airplane in instances where such airplane was provided by an incorporated common carrier of passengers, and while operated by a licensed transport pilot upon a legally-scheduled passenger route between definitely established airports.

4. Said policy expressly provided that there shall be no indemnification for loss caused by hospitalization or surgical expense resulting from:

a. Any condition which was in existence prior to the effective date of the policy.

b. Childbirth.

c. Any sickness requiring a surgical operation unless such sickness had its origin after the expiration of six months from the effective date of the policy.

d. Those incurred during service in the armed forces, or treated in government hospitals, or provided for under Workmen's Compensation Laws.

e. Said policy further expressly provided, among other exclusions and limitations, for no indemnification for expenses due to pregnancy or complications of pregnancy, treatment of mental diseases or derange-

ment or nervous illnesses, war or acts of war; suicide or attempts thereat while sane, and losses resulting from the insured being intoxicated or under the influence of alcohilics (sic) or narcotics unless administered on the advice of a physician.

PARAGRAPH EIGHT: The use by the respondent of the aforesaid false and misleading statements and representations with respect to the terms and conditions of its said policies and its failure to reveal the limitations of said coverage found in said policies have had and now have the tendency and capacity to mislead and deceive and have misled and deceived a substantial portion of the purchasing public into the erroneous and mistaken belief that the aforesaid statements and representations were and are true and to induce said portion of the purchasing public to purchase insurance coverage from the respondent because of said erroneous and mistaken belief.

PARAGRAPH NINE: The aforesaid acts and practices of respondent, as herein alleged, are all to the prejudice and injury of the public and constitute unfair and deceptive acts and practices in commerce within the intent and meaning of the Federal Trade Commission Act.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this 14th day of October, A. D., 1954, issues its complaint against said respondent.

(11)

Failure to file answer within the time above provided and failure to appear at the time and place fixed for hearing shall be deemed to authorize the Commission and Hearing Examiner J. Earl Cox, without further notice, to find the facts to be as alleged herein and to issue the following order in this proceeding:

IT IS ORDERED that the respondent, American Life and Accident Insurance Company, a corporation, and its officers, agents, representatives and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from:

(A) Representing, directly or by implication:

(1) That said insurance policy may be continued in effect indefinitely or for any period of time, when, in fact, said policy provides that it may be canceled by respondent or terminated under any circumstances over which insured has no control, during the period of time represented.

(2) That said policy will pay in full or in any speci-

(12)

fied amount or will pay up to any specified amount for any medical, surgical or hospital service unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented.

(3) That said policy provides indemnification for loss of life in cases where such is not the fact.

(4) That said policy provides for indemnification to insured in cases of sickness or accident generally

or in any or all cases of sickness or accident, when such is not the fact.

(B) Misrepresenting in any other manner or by any other means the terms or provisions of said insurance policy.

The inclusion of such order to cease and desist in this complaint will be without effect in the event you show cause, on or before the 14th day of December, A. D., 1954, why such order should not issue.

IN WITNESS WHEREOF, the Federal Trade Commission has caused this, its complaint, to be signed by its Secretary, and its official seal to be hereto affixed, at Washington, D. C., this 14th day of October, 1954.

By the Commission.

SEAL

ROBERT M. PARRISH,
Secretary.

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(17)

[Caption omitted]

Answer and Motions

Pursuant to the requirements of Rule VIII of the Rules of Practice of the Federal Trade Commission, respondent makes the following answer and alternative motions to the complaint in this proceeding:

1. Respondent admits the allegations of Paragraph One.

2. Respondent admits that during the two years last past it has issued in the State of Missouri insurance policies commonly known and sometimes referred to as "accident and health policies" or "hospital and surgical policies." Respondent admits that at some period during the two years last past it has issued policies designated as "The

Provider Individual or Family Group Hospital-Surgical Policy", "The New Provider Policy" and "The American Plan." Except as herein specifically admitted, respondent denies each and every allegation of Paragraph Two of the complaint.

3. As to Paragraph Three of the complaint, respondent admits that it is licensed to engage in the business of insurance by the State of Missouri as provided by the laws of that State. Respondent is not licensed by any State

other than the State of Missouri. All aspects of respondent's business, including *inter alia*, financial requirements, policy forms, claim practices, advertising practices, are regulated by and subject to the regulation of the laws of the State of Missouri.

Respondent admits that it advertises its policies by mail some of which is sent to various States of the United States in addition to the State of Missouri. Respondent has issued in the State of Missouri insurance policies to persons located in States of the United States other than the State of Missouri. Respondent admits that it is not subject to the jurisdiction of any State other than the State of Missouri because it is not conducting an insurance business in any State other than the State of Missouri. Except as to the extent herein specifically admitted, respondent denies each and every allegation of Paragraph Three of the complaint.

4. Respondent admits that during the two years last past, it has disseminated advertising by means of the United States mails and radio broadcasts. Except as to the extent herein specifically admitted, respondent denies each and every allegation of Paragraph four of the complaint.

5. Respondent denies each and every allegation of Paragraph 5 of the complaint except that it admits that the quotations of purported advertisements contained in said

paragraph are partial quotations taken out of context from materials used by respondent.

6. Respondent denies each and every allegation of Paragraph Six of the complaint.

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7. Respondent denies each and every allegation of Paragraph Seven of the Complaint.

8. Respondent denies each and every allegation of Paragraph Eight of the complaint.

9. Respondent denies each and every allegation of Paragraph Nine of the complaint.

10. Respondent states and alleges that:

(a) The business of respondent does not constitute "commerce" as that term is defined by the Federal Trade Commission Act and respondent is not engaged in commerce.

(b) The business of respondent is "regulated by state law" as that term is used in Public Law 15, 79th Congress (15 U.S.C. § 1011 et seq.), and hence the Federal Trade Commission Act is not applicable to respondent or the business of respondent.

11. Respondent further states that:

In 1948 respondent and a number of other insurance organizations applied to the Federal Trade Commission for a Trade Practice Conference to consider definitive rules relating to the advertising and sales promotion of policies of insurance. This application was granted by the Commission. Trade Practice Conference proceedings were subsequently held in which respondent and its representatives participated. These proceedings culminated in the promulgation by the Federal Trade Commission on February 8, 1950 of Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance. Respond-

(20)

ent was and is signatory to those Rules. At numerous intervals subsequent to the issuance of these Trade Practice Rules representatives of respondent discussed with members of the staff of the Federal Trade Commission advertising materials used by respondent. Respondent also repeatedly on its own motion and at the request of members of the staff of the Commission furnished to the Commission copies of respondent's policies and of all related advertising materials. All suggestions made by the staff of the Federal Trade Commission for amendment, change or alteration in the advertising materials of respondent were promptly put into effect. Indeed respondent had submitted to the Commission the advertising materials, portions of which are quoted in Paragraph 5 of the complaint, prior to the institution of the investigation by the Commission by resolution dated December 15, 1953. Respondent and its representatives were informed by members of the staff of the Commission that such materials were not objectionable and not subject to criticism.

Respondent together with other insurance organizations applied under date of October 28, 1952 to the Commission for a further Trade Practice Conference proceeding to enlarge, clarify and amend the Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance. This application was denied by the Commission under date of November 27, 1953.

Subsequent to the institution of the general investigation by the Commission on December 15, 1953 of advertising practices in the accident and health insurance industry, respondent again furnished to the staff of the Commission

(21)

copies of its advertising materials and policies even though such materials had at prior times been supplied and had been reviewed by the staff of the Commission. At no time prior to the filing of the complaint in this proceeding was respondent informed that the advertising materials, previously reviewed by the staff of the Commission and found

unobjectionable, were in any way subject to an allegation that they constituted unfair and deceptive acts and practices. This, despite the fact that representatives of respondent repeatedly assured the Federal Trade Commission that respondent desired to continue to cooperate with the Commission in the elimination of any advertising practices considered unfair or deceptive.

WHEREFORE, respondent respectfully requests and moves:

1. That the complaint be dismissed on the ground that the Federal Trade Commission Act has no application to the business of respondent.

2. In the alternative, that the complaint be dismissed and the matter be referred to the Bureau of Consultation of the Commission for handling and disposition under the cooperative procedures of that Bureau.

s/ A. ALVIS LAYNE, JR.
A. Alvis Layne, Jr.
Pennsylvania Building
Washington 4, D. C.

s/ WENDELL BERGE
Wendell Berge
Ring Building
Washington 6, D. C.
Attorneys for Respondent

Filed September 25, 1956

(407)

[Caption omitted]

Initial Decision

By J. EARL COX, Hearing Examiner.

* * * * * * * * * * *

The respondent is charged with violating the Federal Trade Commission Act, as that Act is applicable to the

business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 to 1015, inclusive), through the dissemination of false and misleading advertising relating to accident, health, hospital and surgical insurance policies which have been sold in commerce by respondent. This charge is denied. In its answer respondent has also alleged specifically (a) that it is not engaged in commerce as that term is defined in the Federal Trade Commission Act, and (b) that its business is regulated by state law and hence the Federal Trade Commission Act is not applicable to respondent or its business. Further, respondent has set forth in its answer a summary of its past dealings with the Commission, both prior and subsequent to the promulgation in 1950 of the Commission's Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance, alleging that respondent

1. applied for and actively participated in the conference at which such proposed rules were considered;

2. signed said rules and subsequently attempted to cooperate with the Commission by submitting its policies and advertising materials to members of the Commission's staff for consideration and approval, and that respondent was informed that such materials were not objectionable;

3. applied in 1952 for a further conference to enlarge, clarify and amend the Trade Practice Rules; and

4. cooperated with the Commission in its general investigation, instituted in 1953, of advertising practices in the accident and health insurance industry, and repeatedly assured the Federal Trade Commission that it desired to cooperate in the elimination of any advertising practices considered unfair or deceptive.

A motion filed prior to hearing, that the complaint be dismissed for lack of jurisdiction or that the matter be referred to the Commission's Bureau of Consultation, was denied by the Hearing Examiner. A motion also filed prior to hearing, to dismiss on the basis of respondent's prior course of dealing with the Commission and its staff, or in the alternative that the issues pertaining to such prior course of dealing be severed and heard separately from the other issues, was certified to the Commission, which denied the motion, without argument, in its entirety "but without prejudice to respondent's right to renew said request (for a separation of issues and hearing) to the Hearing Examiner".

Thereafter hearings were held, at which evidence in support of and in opposition to the allegations of the complaint was received, duly recorded and later filed in the office of the Commission.

At the close of the case-in-chief in support of the complaint, and before the presentation of any evidence in opposition thereto, respondent moved again to dismiss the complaint for lack of jurisdiction and on the ground that insufficient evidence had been presented to establish that respondent has engaged in unfair or deceptive acts and practices. Both requests were denied—the first on a ruling that the Federal Trade Commission does have jurisdiction over respondent as to the matter at issue in this proceeding; the second on a finding that sufficient evidence had been introduced to establish a *prima facie* case. Proposed findings of fact and conclusions of law have been submitted. Upon the basis of the entire record the following findings and conclusions are made.

I. *Jurisdiction*

The first issue to be determined is that of jurisdiction. Respondent is a corporation organized and doing business under the laws of the State of Missouri, with its home office

at 3805 Lindell Boulevard, in St. Louis. It is licensed in Missouri to engage in life, health and accident insurance business. It has a number of district agency offices in

Missouri, but no offices or agents outside Missouri, and is not licensed in any other state. It prepares advertising, mails advertising material, issues policies, passes on applications and claims, and takes all other action at its home office. Its advertising material is mailed to prospective customers living in states other than Missouri. It also uses radio advertising, which reaches beyond the boundaries of Missouri. During 1953 and 1954 respondent sold and issued policies to residents of each of the 48 states and the District of Columbia. In 1953 its accident and health premium receipts were $380,826, of which $147,634 came from policyholders living elsewhere than in Missouri; in 1954 accident and health premium receipts were $326,710, of which $125,793 was from non-residents of Missouri. Its business in commerce is substantial.

In its decision in *United States* v. *South Eastern Underwriters Association*, 322 U.S. 533 (1944), the Supreme Court held that insurance business, unless confined to a single state, is commerce as the term "commerce" is used in the Constitution, the antitrust laws and the Federal Trade Commission Act. Prior to that time regulation and control of insurance had been exclusively by the states. Following this decision, considerable unrest and uncertainty developed in the insurance industry and among officials of the insurance departments of the various states, which Congress undertook to allay by passing the McCarran Act (Public Law 15, 59 Stat. 33, as amended, 61 Stat. 448, 15 U.S.C. 1011-1015), the pertinent provisions of which read as follows:

> "§2. (a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

"(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

"§3. (a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the

Federal Trade Commission Act, as amended, and the Act of June 19, 1936, known as the Robinson-Patman Anti-discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

"(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation."

Particularly in question in this proceeding is the language of the proviso clause of Section 2(b), which states that the Federal Trade Commission Act, under which this proceeding is brought, "shall be applicable to the business of insurance to the extent that such business is not regulated by State law". Had there been no Public Law 15, it is agreed that the Federal Trade Commission Act would have been applicable to the business of insurance in the same manner and to the same extent as it is applicable to other businesses in interstate commerce, and the precedents of the numerous court decisions on the question of Federal Trade Commission jurisdiction would have been controlling.

It is an established rule of interpretation that Congress cannot be presumed to have done a futile thing, so there must be some meaning to the proviso clause and some areas of activity in which Federal Trade Commission jurisdiction is precluded because of it. The problem in this case is to determine whether the complaint raises issues which project beyond the precluded area.

This proceeding differs from some others now before the Commission in that the respondent here involved is licensed to do business only in its domiciliary state, and carries on all of its interstate business by mail from that state.

The State of Missouri has laws pertinent to this proceeding, two of which provide as follows:

(1) Chapter 376, Life and Accident Insurance, of the Revised Statutes of Missouri, 1949:

"376.590. Misrepresentations, false estimates and circulars prohibited—agents—notes to be held until policy delivered.

1. *No life insurance company doing business in this state,* and no officers, director, or agent thereof, *shall issue or circulate,* or cause or permit to be issued or circulated, *any* estimate, illustration, *circular or statement of any sort misrepresenting the terms of any*

policy issued by it or the benefits or advantages promised thereby, or the dividends or shares of surplus to be received thereon, or shall use any name or title of any policy or class of policies misrepresenting the true nature thereof.

2. Any person who shall solicit an application for insurance upon the life of another shall, in any controversy between the assured or his beneficiary and the company issuing any policy upon such application, be regarded as the agent of the company and not the agent of the assured, nor shall any life insurance company or agent sell, discount or otherwise dispose of any note or notes taken for payment of life insurance premium or premiums, before delivering to the appli-

cant, in person, the policy for which said note or notes shall have been given.

"376.600. Penalty for violating section 376.590.

Any life insurance company which may violate any of the provisions of section 376.590, or which may permit any of its agents or representatives in this state to violate said provisions, *shall have its certificate of authority or license to transact business in Missouri revoked by the state superintendent of insurance, and shall be for a period of five years barred from the further transaction of business in this state;* and any agent, solicitor or representative in this state of any such insurance company who shall violate any of the provisions of said section shall be deemed guilty of a misdemeanor, and, on conviction thereof, in any court of competent jurisdiction in this state, shall be fined not less than fifty nor more than five hundred dollars for each such offense or imprisoned in the county or city jail for not less than ten days nor more than six months, or by both such fine and imprisonment.

(2) Chapter 561, Crimes and Punishment:

"561.660. Publication of untrue, misleading or deceptive advertisements—penalty.

1. Any person, firm, corporation, or association who, with intent to sell or in anywise dispose of merchandise, securities, service or anything offered by such person, firm, corporation or association, directly or indirectly, to the public for sale or distribution or with intent to increase the consumption thereof or to induce the public in any manner to enter into any obligation relating

thereto or to acquire title thereto or an interest therein, makes, publishes, disseminates, circulates, or places before the public; or causes, directly or indirectly, to be made, published, disseminated, circulated or placed before the public, *in this state,* in a newspaper or other publication or in the form of a book, notice, handbill, poster, bill, circular, pamphlet, or letter or in any other way, an advertisement of any sort regarding merchandise, securities, service or anything so offered to the public, which advertisement contains any assertion,

representation or statement of fact which is untrue, deceptive or misleading, shall be guilty of a misdemeanor.

2. And shall upon conviction thereof be punished by a fine of ~~not less than twenty-five dollars nor~~ more than five hundred dollars, or by imprisonment in the county jail not less than ten days nor more than ninety days, or by both such fine and imprisonment; providing, that nothing herein shall apply to any proprietor or publisher of any newspaper or magazine who publishes, disseminates, or circulates any such advertisement without the knowledge of the unlawful or untruthful nature of such advertisement."

(Italics supplied, except for headings.)

The Missouri law also establishes a Division of Insurance headed by a Superintendent of Insurance, which has supervisory power over every insurance company organized and licensed in the state:

(a) to approve or disapprove, before use, every insurance policy offered for sale;

(b) to conduct, every three years or often, examination of the affairs of such companies;

(c) to investigate and take action with respect to complaints relating to payment of claims or to advertising representations;

(d) to require insurance companies to file with it powers of attorney authorizing it to accept, in their behalf, service of process in legal actions in every state in which such company's policy-holders reside.

Under these powers the Missouri Division of Insurance takes action on complaints which arise outside the state as well as on those which come from within.

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Counsel for respondent contend that respondent's business is conducted entirely within the State of Missouri, including all of its activities in furtherance of its advertising program, and that under these laws and to the extent of all the practices charged in the complaint, the respondent is

fully regulated by the state of Missouri to the exclusion of jurisdiction by the Federal Trade Commission.

Under Sections 376.590 and 376.600, the State of Missouri exercises full charter power over the respondent and, for violation of the provisions of law and regulations, can cancel or revoke respondent's charter. Such action would effectually terminate all of respondent's activities, including its advertising practices. Counsel for respondent argue that this power thus to terminate the practices of respondent which are complained of in this proceeding is regulation within the language of Public Law 15, sufficient to preclude Federal Trade Commission jurisdiction. But this argument fails to differentiate between charter power and police power. Public Law 15 does not curtail the one nor extend the other. No matter what may result from this proceeding, the charter power of the State of Missouri will not be curtailed, nor will its police power be extended.

The legislative history of Public Law 15 clearly shows that the phrase "regulated by state law" refers to taxing and policing, not to chartering. Consequently, the contention that Missouri can effectively control or regulate respondent's interstate activities through its power to revoke or suspend respondent's charter fails. The charter power of a state cannot be used as a substitute for its police power, and the instant proceeding is in all essentials a policing action. If respondent's contention were accepted that the charter power of Missouri is so effective, it would lead to the conclusion that the citizens of other states, in which respondent's advertising is circulated, are at the administrative mercy of those officials of the State of Missouri who exercise authority relating only to respondent's charter.

The provisions of Section 561.660 of the Missouri statute, quoted above, are directed to the making, publishing or circulation of misleading and deceptive advertising "in

this state". The limitation "in this state" is specific and clear. If there had been any idea in the minds of Missouri's legislators that the police power of Missouri might extend beyond the state's boundaries, that idea is negated by the unequivocal language of the statute.

It follows, therefore, that there is an area of respondent's activities in which the Missouri statutes do not apply, and in that area the Federal Trade Commission may properly exercise jurisdiction. Section 561.660 of the Missouri statute expressly limits the jurisdiction of Missouri to mis-

leading and deceptive advertising practices carried on within the boundaries of that state; the Federal Trade Commission's authority is applicable to activities taking place across state lines in interstate commerce. The two, therefore do not conflict, and the fact that Missouri still has complete jurisdiction over the respondent so far as charter power is concerned is completely irrelevant to the exercise by the Federal Trade Commission of its police power over false and deceptive acts and practices in interstate commerce.

Accordingly it is concluded that the Federal Trade Commission has jurisdiction over respondent so far as concerns the acts and practices herein complained of.

II. *Issues of Fact*

1. Only two of respondent's policies were offered in evidence. One of these, a doctor's expense policy, may be disregarded because there are no charges of misrepresentation as to it, and there is no evidence as to its sale and distribution. The other, a hospitalization and surgical policy, is referred to as the Provider, or New Provider, policy. At least 2,000 of these policies were issued in 1953 and 1954 to non-residents of Missouri. Some of them were sold by radio, others by mail advertising.

2. Basically, the Provider policy provides indemnity for loss of life by accidental bodily injury, and for hospitaliza-

tion and surgery due to sickness or accident; but through the use of various riders the policy contract can be modified or enlarged to cover a variety of contingencies, and the respondent refers to its combined available coverages as the American Plan. Some riders are applicable to and provide for maternity benefits, additional surgical benefits, and additional hospital-room benefits.

Respondent's Advertising and Business Practices:

3. Respondent has used radio stations KMOX and WEW, of St. Louis, WBEM of Chicago, KOAM of Pittsburg, Kansas, and an unidentified station in Kansas City to interest the public in its Provider policy and to induce inquiries by mail for further information. The number of sales resulting from this advertising cannot be determined, but in every instance information in addition to that contained in the radio script was furnished to the prospect. Only one radio script is shown in the record, and there is no evidence as to the number or source of inquires received as a result of its use. Respondent's radio advertising ceased in 1954. Respondent has used no newspaper or magazine advertising. The names of prospects have come in from the radio advertising or were procured through policy-holders.

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4. Upon receipt of the name of a prospective purchaser of accident and health insurance, respondent company sent its first form-letter, which always was accompanied by a brochure describing the policy, two application forms, and a return envelope addressed to the company. Sometimes one or more stuffers describing benefits or containing favorable comments from policy-holders were enclosed. There were approximately a dozen varieties of such stuffers. Often a miniature (half-size) policy, and a form for recommending names and addresses of friends who might be interested in respondent's policies, were included. During the latter part of 1954, the mailing of the brochure was

discontinued and a copy of the policy has since been substituted in its place and included in all mailings.

5. About the tenth day after the mailing of this first letter, if no favorable reply was had, the company sent out a second letter, with which was enclosed the brochure, two application forms and sometimes one or more of the stuffers (during the latter part of 1954 and thereafter the miniature policy was used instead of the brochure). Thereafter eight more form letters were mailed in sequence with similar enclosures. The first two of these were mailed at ten-day intervals, the last six at intervals of thirty days. How many of these letters were sent out and the areas into which they were mailed is not disclosed.

6. The number of policies that may have been purchased as a result of any one of these mailings cannot be determined. It is reasonable to conclude that some policies were purchased following each mailing, but after the first mailing the inducing cause of a purchase may have been the cumulative effect of all the literature received, or it may have followed from a specific statement contained in any one of the pieces of literature received.

7. Each person who desired one of respondent's policies sent in his application and initial premium payment by mail. The statements contained in the application were relied upon by respondent, except for an occasional credit check, and no medical examination was required. Upon approval of an application, a policy was issued by respondent and mailed. If a policy lapsed, respondent sent the policyholder a "conservation" letter, to which was attached a reinstatement application. If no favorable response was received within six months, a second lapse-letter with another reinstatement application was mailed. Claims were also handled by mail.

Representations:

8. By the various advertising statements used, the complaint alleges four specific false, misleading and deceptive

representations have been made by respondent with respect to its Provider policy. These will be discussed seriatim.

9. The first such allegation is that the respondent has falsely represented

> "That the indemnification provided by said policy against loss caused by hospitalization and surgical operations as a result of sickness or accident, can be continually renewed at the option of the insured, regardless of impairment of risk due to the incidence of sickness or accident, in some cases up to 65 years of age and others up to 75 or 90 years of age".

10. The statements appearing in respondent's advertising material upon which this charge of misrepresentation is based are set forth in the complaint as follows:

(1) "No Reduction of Benefits On Account of Age";

(2) "There is no reduction in benefits, ever. Even children who pay a lower premium receive full benefits, just like an adult";

(3) "Benefits do not reduce because of age";

(4) "(We are again enclosing descriptive literature, also calling your attention to a few important facts which you may have overlooked.) There is no reduction of benefits for minors or for older persons. The premiums are NOT increased because of age (except in the case of children when they attain age 18) nor is the policy ever cancelled because of age. Hospital room, board and general nursing care benefits are paid for one day and up to one year if you have to stay that long. Persons up to age of ninety are eligible . . . ";

(5) "Individual and Family Groups from Birth to 65 years of Age are Eligible to Apply for this Policy * * * the features and liberal benefits are available

> to all from birth to 65 years of age who are in good health. No matter where you live you are eligible for the New Provider Policy".

Other similar statements appear in respondent's advertising literature.

11. Quotations (1), (2) and (3), above, state clearly that the benefits payable under the policy are constant in amount regardless of the age of the insured. They do not refer to policy renewability, and cannot reasonably be so regarded. Quotation (4) goes one step further, asserting that the policy is never cancelled because of age, which, to one not

familiar with the distinction between cancellability and renewability, merely reaffirms the statements made in (1), (2) and (3). Quotation (4) also states that persons up to 90 years of age may apply for respondent's policy. Quotation (5) indicates a 65-year age limit for eligibility to apply. None of the statements refer to policy termination.

12. In the *American Hospital and Life Insurance Company* matter, Docket 6237, page 11, the Commission, interpreting similar statements, said:

> "We do not believe that these (two) statements, separately or together, particularly in the absence of assertions of lifetime duration or any other definite period of coverage, can be reasonably read as meaning more than that respondent's policies contain no provisions terminating or reducing benefits on account of increasing age and that applicants for such policies must be within the age limits specified. It is true that respondent's accident-and-health policies are term contracts renewable at the option of the company on the premium date. However, nothing to the contrary is expressed or reasonably implied in the aforequoted statements and we therefore discern therein no capacity or tendency to deceive."

13. The Commission's decision is controlling; therefore the complaint in this respect should be dismissed.

14. The second allegation of misrepresentation is that the respondent has advertised that the Provider policy "provides up to $100.00 indemnity for surgical expense resulting from each or all of 64 different surgical operations", whereas, in fact, $100.00 indemnification is provided for only one operation, namely, cutting into the cranial cavity. The policy sets forth a schedule of 64 different operations and states maximum indemnity for each; for each of 60 the insured is offered indemnification of $50.00 or less; for each of two others indemnification is $60.00; for one other $75.00; and for the cranial operation, $100.00. The policy also contains a limitation that not more than one, the greater, of the amounts specified in the schedule will be paid on account of any one sickness or for injury resulting from any one accident.

15. Among the advertising statements on which the foregoing allegation is predicated are the following:

The radio script contains the statement;

> " * * * sickness requiring surgery covered after policy has been in force six months * * Benefits for 64 specific surgical operations".

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The brochure states:

> "YOU GET $5.00 TO $100.00
> For surgical operations you get from $5.00 to $100.00 to help you pay your surgeon while hospitalized. There are 64 operations listed in the Schedule of Operations."

In the first form letter appears the following:

> "In addition, the policy will pay you benefits for 64 surgical operations, as well as benefits for ambulance, blood transfusions, oxygen tent, and rental of wheel chair or crutches. * * ".

16. In two cases similar language, used in somewhat different context, has been interpreted. Each of the two examiners who heard these cases separately found that the

language complained of was not deceptive, but upon appeal the Commission, in both cases, held to the contrary, concluding that the language is misleading and deceptive.

17. In the *American Hospital and Life Insurance Company* case, Docket 6237, decided April 24, 1956, the language to be interpreted was as follows:

"SURGERY	
from $3.00 to $150.00 *depending on seriousness of operation"*	$150.00 (Italics added)

The Commission said:

> "Appraising this advertisement as it is likely to be read by unsuspecting, incautious members of the purchasing public, we gain the impression that the policy will indemnify up to a maximum sum of $150 for any surgical operation serious enough to cost such an amount."

18. In the *National Casualty Company* case, Docket 6311, decided May 21, 1956, the Commission quoted from the *American Hospital* decision, and added:

> "Our conclusion is no different here. As the courts have uniformly recognized, it is not the trained and experienced experts who need protection, but the members of the buying public who, in making purchases, are governed largely by appearances and general impressions. Furthermore, the ultimate impression upon the

> mind of a reader arises from the sum total of not only what is said in an advertisement but also of all that is reasonably implied. *Charles of the Ritz Dist. Corp.* v. *Federal Trade Commission*, 143 F. 2d 676 (C.A. 2, 1944). And it seems obvious to us that the statements referred to, *especially when read in conjunction with such superlatives* as 'The Most Complete Coverage,' 'Complete Protection', 'All Inclusive Hospital—Surgical—Nurse Protection,' and 'Maximum Protection at Moderate Cost,' which have also appeared in the respondent's advertisements, are almost certain to mislead readers into thinking they are getting protection

which the policies do not provide. The respondent's practice of describing in its advertising the maximum benefits that may be received under the policies without disclosing the schedule of payments for which the policies actually provide is thus unfair and deceptive within the meaning of the Federal Trade Commission Act" (Italics added).

19. Respondent points out that its advertising differs from the advertising interpreted by the Commission in these two cases, but in the last sentence quoted above from the *National* case the Commission indicates its belief that insurance advertising should disclose "the schedule of payments for which the policies actually provide". This the respondent in the instant case did not do, except when a sample policy was enclosed with the literature mailed to a prospective purchaser. This failure on the part of the respondent brings its advertising within the scope of the Commission's ruling in the *National* case, and, upon the basis of the Commission's decision in that case, it is concluded that respondent's advertising is, in this respect, deceptive and misleading.

20. The third allegation of misrepresentation is that respondent has represented that the lump sum benefit for loss of life due to travel accident in a common carrier by land, water or air is without other qualification or limitation. This is charged to be deceptive and misleading, since it differs from the policy provision, which is as follows:

"If death of the insured shall result solely from accidental bodily injury within 90 days after such injury, while riding as a fare-paying passenger in any public conveyance including a licensed passenger airplane provided by an incorporated common carrier of passengers and while operated by a licensed transport pilot upon a regularly scheduled passenger route between definitely established airports, the Company will pay in lieu of all other indemnity, Travel Accidental Death Benefit of Twenty-Five Hundred Dollars ($2500.00)."

21. Among respondent's advertising statements are the following:

"Benefits for loss of life by travel accident."

"The New Provider Hospitalization Policy pays your beneficiary, in lieu of other benefits, $2,500 for death as a result of accident while travelling on a public conveyance (or common carrier) by land, water or air."

"You are covered for death as a result of an accident while travelling as a fare-paying passenger in a common carrier by land, water, or air."

"There is also a lump sum benefit $2,500.00 for loss of life due to travel accident by land, water or air."

"Pays $2,500.00 lump sum benefit for travel accidental death, at no extra cost."

22. The foregoing advertising statements are not false, but they do not disclose fully the terms and conditions applicable to the payment of indemnification for accidental death.

23. Respondent contends (a) that there can be no deception by the failure to set forth in the advertising the provision that death must result within ninety days after injury, since this provision is never enforced by the company and may not be interjected as a basis for rejecting any claim under the rules of the Missouri Department of Insurance; (b) that it is specifically stated in the brochure, and by clear inference disclosed in its other advertising literature, that a claimant policy-holder must have been a fare-paying passenger on a common carrier; and (c) that under the ruling in *Alberty* v. *F.T.C.*, 182 F. 2d 36, the Federal Trade Commission may not require a respondent to disclose information not required to prevent falsity, and therefore that respondent's failure to state in its advertising the limitation that if death results from an air-travel accident it must have happened in a "licensed passenger airplane provided by an incorporated common carrier

of passengers and while operated by a licensed transport pilot upon a regularly scheduled passenger route between definitely established airports", and that the accidental injury must be the sole cause of the death, is not such a failure as to support action by the Federal Trade Commission.

24. Even if contentions (a) and (b) be accepted, under the Commission's recent rulings and decisions, contention

(c) must be rejected, and the conclusion reached that respondent's failure to disclose fully in its advertising matter the terms and conditions upon which indemnification will be made in case of accidental death constitutes unfair and deceptive advertising within the meaning of the Federal Trade Commission Act.

25. Among the advertising statements upon which the fourth set of charges of the complaint is based are the following:

> "As an example, Friends, unlike other Hospitalization plans, this policy pays benefits for hospital room and board for one day, one week, one month or a whole year. Government hospitals, which are usually free are excepted. No waiting 30 or 60 days, it covers you immediately for all accidents and all sickness not requiring surgery. . . . sickness requiring surgery covered after policy has been in force six months . . . Benefits for 64 specific surgical operations . . . Benefits for loss of life for travel accident . . . for those who want it a Maternity Rider is available at a small additional charge . . . EXTRA BENEFITS SUCH AS CASH FOR BLOOD TRANSFUSIONS . . . RENTAL OF WHEEL CHAIR OR CRUTCHES . . . OXYGEN AND AMBULANCE FEES . . . NO DEDUCTION OF BENEFITS ON ACCOUNT OF AGE" (Radio script).
>
> ". . . ALSO PAYS benefits for hospitalization due to sickness, accident or surgery. Full benefits paid to children. To our knowledge, the NEW PROVIDER POLICY is the most liberal yet the lowest priced hospitalization plan now available. Read inside for all

the tremendous advantages and cash benefits offered . . ..all for only 3¢ a day! . . .'' (Brochure).

". . . NOTE: For those who want it, a Maternity rider is available at small additional charge. Confinement in Government hospitals, or any Institution that is not equipped with a laboratory, operating room, and Registered Nurse, always on duty, are not covered. Sickness resulting in surgery is covered if the cause originates after policy has been in force six months . . .'' (Brochure).

"YOU GET $5.00 TO $1,825.00

If sickness strikes and you enter any hospital, you will receive actual expenses and not to exceed $5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year'' (Brochure).

"YOU GET $5.00 TO $1,825.00

If accident strikes and you enter any hospital, benefits begin at once. You will receive actual expenses not to exceed $5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year'' (Brochure).

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" . . The policy goes into effect immediately, from the first day of hospital confinement for either sickness or accident, except in the case of sickness requiring a surgical operation, then the usual six months waiting period applies'' (First form letter).

"Send in your application right now, while it is still fresh in your mind. The self-addressed envelope needs no postage and you will get your PROVIDER policy within a few days by mail. It will be in full force when the mailman delivers it to you'' (Ninth form letter).

"I represent to my best knowledge that all persons named are in good health and that there is no existing condition which may require either Hospitalization or Surgical operation, except as follows: . . . . . .

. . . . . .''

(Application form, second paragraph).

26. Through these and other similar statements, it is alleged that the respondent has falsely and deceptively represented "that the said policy provides indemnification for loss caused by hospitalization or surgical expense resulting from any or all sicknesses or accidents except

"a. Those existing conditions which, in the opinion of the insured, might require either hospitalization or operation and which were set forth in good faith by the insured in his application for said policy, or for any renewal thereof, and which were subsequently excepted specifically from coverage by indorsement on the policy;

"b. Childbirth, unless covered by special rider;

"c. Sickness requiring a surgical operation prior to the expiration of six months from the effective date of the policy;

"d. Those incurred during service in the armed forces, or treated in Government hospitals, or provided for under Workmen's Compensation Laws;".

27. It is charged that such representations are false, misleading, and deceptive, because, in truth and in fact, respondent's policy expressly provides that "there shall be no indemnification for loss caused by hospitalization or surgical expense resulting from:

"a. Any condition which was in existence prior to the effective date of the policy;

"b. Childbirth;

"c. Any sickness requiring a surgical operation unless such sickness had its origin after the expiration of six months from the effective date of the policy;

"d. Those incurred during service in the armed forces, or treated in government hospitals, or provided for under Workmen's Compensation Laws; (and)

"e. Said policy further expressly provided, among other exclusions and limitations, for no idemnification for expenses due to pregnancy or complications of

pregnancy, treatment of mental diseases or derangement or nervous illnesses, war or acts of war, suicide or attempts thereat while sane, and losses resulting from the insured being intoxicated or under the influence of alcoholics or narcotics unless administered on the advice of a physician".

The general charge is that the respondent has falsely and deceptively represented that, except for specific limitations hereinafter discussed, its policy provides indemnification for losses or expenses resulting from any or all sicknesses and accidents.

28. Respondent's policy does not so provide. Specifically excluded from coverage under respondent's policy are mental disease or derangement or nervous ailments, any loss caused by war or any act of war, suicide or attempt thereat while sane, disease contracted or injury incurred while the insured is engaged in the commission of a felony or in an illegal occupation, or resulting from the insured being intoxicated or having used narcotics without advice of a physician. Since these limitations and conditions are not disclosed in respondent's advertising used during the period herein involved, this lack of disclosure, under the decisions of the Commission, constitutes unfair and deceptive acts and practices.

29. In addition to the general charge, there are some specific charges alleged. Subparagraph "a" above quoted, if stated affirmatively, is that respondent has advertised that its policy provides indemnification for expenses due to all sicknesses and accidents arising out of conditions which existed prior to the effective date of the policy excepting those pre-existing conditions "which were set forth in good faith by the insured in his application for said policy, or for any renewal thereof, and which were subsequently excepted specifically from coverage by indorsement on the policy". Considerable interpolation of language into respondent's advertising material, whether taken in

toto or sentence by sentence, and an unrealistic exaggeration of inferences based largely on such interpolations, would be required before one could deduce from respond-

ent's advertising material this specific representation charged in the complaint. For any insurance company to make such a representation would be an invitation to fraud and litigation. It must be concluded, from the evidence adduced, that no such representation has been made by respondent.

30. In subparagraph "b" it is alleged that respondent has represented that its policy does not provide indemnification for childbirth, unless covered by specific rider; hence no one would expect childbirth to be covered by the policy itself. Yet, in Paragraph Seven of the complaint it is charged that the representation is false because childbirth is not covered by the policy. The evidence shows that respondent offers a maternity rider which undoubtedly covers childbirth. There is no deception in this respect.

31. In subparagraph "c" it is alleged that respondent has represented that its policy does not cover "sickness requiring a surgical operation prior to the expiration of six months from the effective date of the policy". In the fourth advertising statement quoted in Paragraph Five of the complaint, taken from the brochure which was respondent's chief piece of advertising matter and accompanied all letters, appears this sentence:

> "Sickness resulting in surgery is covered if the cause originates after policy has been in force six months."

The charge in subparagraph "c" of Paragraph Seven of the complaint is that respondent's alleged representation, above quoted, is false and deceptive because the policy excludes indemnification arising out of "any sickness requiring a surgical operation unless such sickness had its origin after the expiration of six months from the effective date of the policy". It is difficult to understand why this

charge was included in the complaint. It is without support in the record. The policy exclusion is exactly as stated in respondent's advertising.

32. In subparagraph "d" of Paragraph Six it is alleged that respondent has represented that its policy coverage excludes losses or expenses resulting from sickness or accidents "incurred during service in the armed forces, or treated in Government hospitals, or provided for under Workmen's Compensation Laws"; then in subparagraph "d" of Paragraph Seven, it is charged that the representation is deceptive because exactly the same exclusion is contained in respondent's policy. Again, inclusion of this charge in the complaint is inexplicable. Being without justification or support, it too must fail.

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Abandonment:

33. Based upon the findings hereinabove stated, an order may be issued requiring respondent to disclose clearly, accurately and conspicuously the terms, conditions and limitations of its policies, or, if it is found that the acts and practices complained of have been discontinued and a resumption thereof is not reasonably to be anticipated, the proceeding may, under the discretionary powers of the Commission, be dismissed without prejudice.

34. In June, 1954, prior to the commencement of this proceeding, respondent abandoned use of the brochure which was its chief piece of advertising literature and contained most of the statements herein complained of. At the same time the use of the radio script alleged to be objectionable ceased. Respondent states affirmatively that it has discontinued all the representations complained of; that it will not resume their use; and that it stands ready to make any change in its advertising matter or practices that the Commission, or any responsible member of the Commission staff, may suggest. On June 16, 1956, one day after promulgation thereof, respondent subscribed to

and agreed to comply with the Commission's Trade Practice Rules for the Accident and Health Insurance Industry.

35. Based on respondent's prior course of conduct, the conclusion is that a resumption by respondent of the discontinued practices cannot reasonably be anticipated, and that respondent is sincere in its offer of cooperation with the Commission. Respondent was one of the parties suggesting the conference which resulted in the preparation of the Trade Practice Rules for the Advertising and Sales Promotion of Mail Order Insurance promulgated by the Commission on February 3, 1950; it subscribed to those rules; it has since submitted its advertising material for consideration and suggestion to the Commission's Bureau of Industry Cooperation, now the Bureau of Consultation; when suggestions were offered by members of the Commission's staff, respondent changed its advertising in accordance therewith; in 1952 it joined with others, in a request for a conference for further consideration of the Trade Practice Rules, which request was denied by the Commission; respondent's attorney has held numerous conferences with members of the Commission's staff, during which respondent's advertising statements and representations were discussed; respondent cooperated fully when the Commission entered upon the general investigation of accident and health insurance advertising; and it participated in the conferences preceding the adoption of the Rules promulgated June 16, 1956. Respondent has shown its good faith by word and deed.

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36. This course of conduct on the part of respondent leads to the conclusion that everything that could be accomplished by a cease-and-desist order in this matter has already been accomplished.

III. *Conclusions*

Upon the basis of the entire record the following conclusions are reached:

1. that this proceeding is in the public interest;

2. that the Federal Trade Commission has jurisdiction over respondent and all matters at issue in this proceeding;

3. that respondent's advertising representations have been unfair, misleading and deceptive, to the prejudice and injury of the public and in violation of the Federal Trade Commission Act, in that the advertising statements and representations (a) as to indemnification for surgical expenses, (b) as to benefits payable for loss of life due to travel accidents, and (c) as to indemnification for loss caused by hospitalization or other expenses due to sickness and accident; have failed to disclose fully the terms, conditions and limitations applicable, under its policies, to the payment of such benefits or indemnities;

4. that in all other respects the charges of the complaint have not been proved by substantial, reliable, probative evidence; and

5. that since the acts and practices complained of in this proceeding have been discontinued and no reasonable likelihood exists that they will be resumed by the respondent, all that could be accomplished herein by the issuance of a cease-and-desist order has already been accomplished, and the proceeding should be dismissed without prejudice.

Therefore,

It Is Ordered that the complaint herein be, and the same hereby is, dismissed without prejudice to the right of the Commission to take such further action as it may deem appropriate.

J. Earl Cox
J. Earl Cox,
Hearing Examiner.

September 24, 1956.

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[Caption omitted]

Final Order

Counsel supporting the complaint having timely filed an appeal from the initial decision of the hearing examiner in this proceeding; and the matter having been heard by the Commission on briefs and oral argument; and the Commission having rendered its decision granting the appeal of counsel supporting the complaint and directing modification of the initial decision in conformity with the Commission's opinion;

It Is Ordered that the following paragraphs numbered 10 and 11 be, and they hereby are, substituted for Paragraphs 10 through 13, inclusive of the findings of fact contained in the initial decision:

"10. The following and similar statements appearing in respondent's advertising material constitute the basis for this charge of misrepresentation:

(1) 'Benefits do not reduce because of age.'

(2) 'There is no reduction of benefits, ever.'

(3) 'Benefits are not reduced because of age.'

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(4) '* * * There is no reduction of benefits for minors or for older persons. The premiums are NOT increased because of age (except in the case of children when they attain age 18) nor is the policy ever cancelled because of age. Hospital rooms, board and general nursing care benefits are paid for one day and up to one year if you have to stay that long. * * *'

(5) 'The policy will NOT be cancelled, EVER because of age.'

(6) '* * * the features and liberal benefits are available to all from birth to 65 years of age who are in good health. * * *'

"11. Through use of the foregoing statements and others of similar import respondent directly or by

implication has represented that its 'New Provider' policy will continue to offer protection to an insured up to age 65 with full indemnification. To a prospective purchaser of such a policy this is an important feature. In fact, however, the policy specifically provides that the respondent, at its option may refuse to accept any renewal premium for any reason whatsoever, thus, in effect cancelling its contract with the insured. Under the express terms of the policy an insured may be cancelled out on any premium anniversary date even though he may have paid premiums over a period of many years without having made any claim whatever upon respondent."

It Is Further Ordered that the following paragraph be, and it hereby is, substituted for Paragraph 29 of the initial decision:

"27. In addition to the general charge, there are some specific charges alleged. One of these is to the effect that respondent represented by implication that

its 'New Provider' policy indemnifies for loss of time due to conditions existing prior to the effective date of the policy which are not listed on insured's application for a policy. In truth and in fact respondent's 'New Provider' policy expressly excepts from its coverage any indemnity for * * * any condition which was in existence prior to the effective date of this policy or at the time of any reinstatement * * *. Thus, respondent indicates its coverage is all inclusive 'with certain exceptions'; but when compared with the policy these statements are misleading and deceptive."

It Is Further Ordered that Paragraphs 14 through 28, both inclusive, of the initial decision be renumbered 12 through 26, both inclusive.

It Is Further Ordered that Paragraphs 30 through 36, both inclusive, be deleted from the initial decision.

It Is Further Ordered that the following paragraphs be, and the same hereby are, substituted for that portion of the initial decision designated "III. *Conclusions.*"

"III. *Conclusions*

Upon the basis of the entire record the following conclusions are reached:

1. The Federal Trade Commission has full jurisdiction of this proceeding.

2. The public interest in which this proceeding is brought, is clear and substantial.

3. Actual deception need not be shown, tendency or capacity thereto, from the representations made, being sufficient.

4. The use by respondent of the statements and representations as found herein to be deceptive and misleading, as they relate to the terms and conditions of its policies of insurance, and the failure by respondent to reveal the limitations of the coverage of said policies, have the tendency and capacity to mis-

lead and deceive a substantial portion of the purchasing public into the erroneous and mistaken belief that said statements and representations are true and to induce the purchase of said policies of insurance because of such erroneous and mistaken belief.

5. The aforesaid acts and practices of respondent, as above set forth, are all to the prejudice and injury of the public and constitute unfair and deceptive acts or practices within the intent and meaning of the Federal Trade Commission Act."

IT IS FURTHER ORDERED that the following order be, and it hereby is, substituted for the order contained in the initial decision:

"IT IS ORDERED that the respondent, American Life and Accident Insurance Company, a corporation, and its officers, agents, representatives and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as 'commerce' is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from representing, directly or by implication:

1. That any such policy may be continued in effect by the insured upon payment of stipulated premiums, indefinitely or for any stated time, unless full disclosure of any other provision or condition of termination contained in the policy is made conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.

2. That said policy provides for payment in full or in any specified amount or for payment up to any specified amount for any medical, surgical or hospital service, unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented, or unless full dis-

closure of the schedule of payments for which the policy provides is made conspicuously, prominently and in sufficiently close conjunction with said representation as will fully relieve it of all capacity to deceive.

3. That said policy provides for indemnification against losses due to sickness or accident, unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnifications actually provided are set forth conspicuously, prominently, and in sufficiently close conjunction with said representations as will fully relieve it of all capacity to deceive.

4. That said policy provides for a stipulated sum to be paid upon the accidental death of the insured unless full disclosure of the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive."

It Is Further Ordered that respondent, American Life and Accident Insurance Company, shall, within sixty (60) days after service upon it of this order, file with the Commission a report, in writing, setting forth in detail the manner and form in which it has complied with the order to cease and desist.

IT IS FURTHER ORDERED that the initial decision of the hearing examiner, as modified herein, is hereby adopted as the decision of the Commission.

By the Commission.

SEAL

s/ ROBERT M. PARRISH
Robert M. Parrish,
Secretary.

Issued: April 19, 1957.

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(513)

[Caption omitted]

Opinion of the Commission

By Secrest, Commissioner:

Respondent American Life and Accident Insurance Company is engaged in the sale of accident and health insurance and is licensed to do business only by the State of Missouri. It conducts its business in all other states by mail. The complaint herein charged respondent with false and misleading and deceptive practices in the solicitation and sale of one of its accident and health policies in violation of Section 5 of the Federal Trade Commission Act. As indicated, only respondent's "Provider" or "New Provider" policy is involved here. The complaint charged four specific misrepresentations as to the "New Provider" policy covering:

(1) its renewability or duration;

(2) the maximum amounts provided for surgical operations under a surgical schedule;

(3) certain limitations upon travel death benefit provisions; and

(4) the general classes of sickness and accidents covered.

(514)

The hearing examiner's initial decision dismissed the charge in the complaint relating to renewability or duration. He found that representations as to maximum amounts payable for surgical operations were false and misleading. As to representations with regard to travel death benefit provisions, the initial decision found respondent's representations in this regard to constitute unfair and deceptive advertising. With respect to the charge of misleading advertising of indemnification for all sickness and accidents, the hearing examiner found these generally to have been substantiated but failed to declare as false and misleading specific representations attacked in the complaint regarding indemnification for conditions existing prior to the effective date of the policy, coverage for childbirth, indemnification for surgery required prior to expiration of six months from the effective date of the policy, and coverage for sickness or accident "incurred during service in the armed forces, or treated in Government hospitals, or provided for under Workmen's Compensation Laws."

Finally, the hearing examiner made the requisite findings as to the existence of public interest and jurisdiction and concluded that respondent's advertising representations were unfair, misleading and deceptive in the respects indicated. He ordered the complaint dismissed, however, on the ground:

> "that since the acts and practices complained of in this proceeding have been discontinued and no reasonable likelihood exists that they will be resumed by respondent, all that could be accomplished herein by the issuance of a cease and desist order has already been accomplished * * *."

Counsel supporting the complaint have appealed from the initial decision and the matter is now before us for

final decision on the merits on the basis of the whole record, briefs on appeal and in opposition thereto and on oral argument before the Commission.

Counsel supporting the complaint contend that respondent has failed to provide any reasonable basis for dis-

(515)

missal of the complaint on the ground of discontinuance of practices charged. In support of the conclusion that respondent has abandoned the practices complained of, the hearing examiner refers to respondent's prior course of dealings with the Commission in connection with respondent's activities relative to certain trade practice conference rules for mail order and health and accident insurance. It is our opinion that while respondent's prior course of dealing with the Commission might have some bearing on respondent's good faith, the record as a whole does not support the contention that the respondent has in fact discontinued use of the practices alleged to be unlawful.

The facts are that respondent discontinued radio advertising in 1954, prior to commencement of this proceeding, and the hearing examiner correctly so found. Also, the record shows that use of a brochure which accompanied respondent's mailings to prospective customers likewise was discontinued at the same time. The radio script and brochure contained most of the representations alleged to be deceptive. However, there is no evidence that respondent has discontinued the use of ten form letters mailed in series to each prospective customer unless and until an application for a policy is forthcoming. (Since the latter part of 1954, a sample copy of the "New Provider" policy has accompanied all such letters in all mailings.) And, from our examination of these form letters, received in the record as exhibits, we conclude that respondent is continuing the use of most, if not all, of the deceptive representations, or statements substantially similar to them—all as more particularly set forth in the Commission's findings of fact herein. We also are of the

opinion that the fact that a sample copy of respondent's "New Provider" policy currently accompanies each of the series of ten form letters does not cure the patently deceptive nature of the misrepresentations contained in those form letters. In *American Hospital and Life Insurance Company, supra*, in similar circumstances, the Commission held as follows:

(516)

"Rather it is our view that the brochure functions as a self-contained piece of advertising that of itself is likely to induce a prospect to purchase respondent's insurance.

"Furthermore, we do not believe that the prospective purchaser is under any obligation to investigate the extent to which respondent's unrestricted representations of coverage for illness or accidents are untrue. 'Under repeated decisions, the purchaser is entitled to rely upon the representations made. He need not distrust what is told him. * * * It goes without saying almost that it is extremely difficult for a layman to understand the terms and conditions of such policies as these, but whether the applicants did or did not read and understand the policies is beside the point.' *United States* v. *Sylvanus*, 192 F. 2d 96, 105 (7th Cir. 1951) cert. denied, 342 U.S. 943 (1952).

"If the busy or careless businessman is entitled to protection from deceptive printed forms, even though an attentive, careful person would not be deceived thereby, *Independent Directory Corp.* v. *F.T.C.*, 188 F. 2d 468, 470, 471 (2d Cir. 1951), it does not devolve upon respondent's prospects to ascertain the extent to which respondent's advertising may or may not exaggerate or falsify. The Federal Trade Commission Act is violated if the first contact or interview is secured by deception even though the true facts are made known to the purchaser before he enters into the contract of purchase. *Carter Products, Inc.* v. *F.T.C.*, 186 F. 2d 821, 824 (7th Cir. 1951).

"Another questionable premise in the examiner's reasoning is that 'any reasonably intelligent person considering the purchase of health and accident insurance would be expected to know that health and

accident policies do not ordinarily cover all illnesses

> and all accidents, regardless of their nature or time of origin or occurrence.' Apart from the fact that the Federal Trade Commission has the duty to protect not only the 'reasonably intelligent' but also the ignorant, the unthinking, the credulous, and the inexperienced, *Charles of the Ritz Dist. Corp.* v. *F.T.C.*, 143 F. 2d 676, 679 (2d Cir. 1944), we question whether the fact asserted by the examiner to be common knowledge—if it be a fact—is generally known even to the 'reasonably intelligent.' It is certainly not beyond the realm of actuarial conceivability, not to say possibility, that in these United States in the mid-twentieth century insurance could be written which would afford protection against all illness and all accidents."

These principles are controlling here and the hearing examiner clearly erred in holding that respondent has discontinued the practices questioned in the complaint in this proceeding with reasonable assurance that they will not be resumed. The facts of record are to the contrary. The initial decision will be modified accordingly.

Having thus ruled on the matter of discontinuance, the Commission has before it only two other questions for consideration. Are respondent's representations as to the renewability and duration of its "New Provider" policy deceptive and misleading? Has respondent misrepresented the general classes of sickness and accidents against which the policy indemnified, including illness originating before issuance of the policy?

The hearing examiner's initial decision found that respondent's representations as to amounts payable for surgical operations (Initial Decision, Paragraphs 14 through 19, both inclusive) and as to travel death benefit provisions (Initial Decision, Paragraphs 20 through 24, both inclusive) constitute misleading and deceptive advertising. With these findings we are in agreement and we do not propose to disturb them.

On the matter of renewability or duration of respondent's policy, the hearing examiner dismissed the charges of the complaint on the authority of *American Hospital and Life Insurance Company, supra.* In this connection, counsel supporting the complaint point out that the particular charge in the *American Hospital* case was dismissed by the Commission because the advertising stated "NO AGE PROVISION terminating or reducing benefits because of increasing age." The Commission held such statement literally to be true inasmuch as respondent's policies did not contain a provision reducing benefits because of age.

Here, respondent, in its form letters, states as follows:

> "Benefits do not reduce because of age." (Comm. Exs. 3, 10, 18.)
>
> "There is no reduction in benefits, ever." (Comm. Ex. 8.)
>
> "There is no reduction of benefits for minors or older persons * * * nor is the policy ever cancelled because of age * * * persons up to age of ninety are eligible." (Comm. Ex. 22.)
>
> "The policy will not be cancelled, ever, because of age." (Resp. Ex. 8.)

We conclude that such statements give the impression that respondent's "New Provider" policy will continue in effect with full indemnification so long as the insured pays premiums and that such representations constitute false and misleading representations that respondent's policies may be kept in force continuously at the option of the insured when, in fact, the policies are terminable at any premium date at the option of respondent. *National Casualty Company*, Docket No. 6311, decided May 21, 1956.

The fourth specific misrepresentation charged in the complaint is that respondent has falsely and deceptively represented that its "New Provider" policy, with certain

specific exemptions, indemnifies against losses or expenses resulting from *any or all* sicknesses and accidents. On the facts as disclosed by the record, the hearing examiner found that respondent misrepresented the scope of sickness and accident coverage provided by its policy because of inadequate disclosure in advertising of the exceptions to such coverage as provided in the policy.

The examiner further found, however, that respondent's advertising is not susceptible of the interpretation that it represents that its policy covers all sickness or accidents arising out of conditions which existed prior to the effective date of the policy, and, this finding is assigned as error by counsel supporting the complaint.

The initial decision (Paragraphs 30, 31 and 32) interprets the complaint as alleging that respondent's advertising is deceptive because it represents, contrary to the fact, that its policy does not cover childbirth and certain other conditions. The Commission does not construe the complaint as so charging and is of the opinion that the pertinent portions of the complaint involved[1] merely recite conditions represented in respondent's advertising as being expressly excluded from indemnification under the policy for the purpose of emphasizing conditions that were not clearly shown in respondent's advertising as not being covered by its "New Provider" policy. It follows, therefore, that there is no basis for the findings contained in the aforesaid paragraphs of the initial decision.

As to the appeal of counsel supporting the complaint, we agree that respondent's advertising inescapably implies that coverage of its policy is comprehensive but for the exceptions stated in said advertising. It is clear that respondent's "New Provider" policy by its express terms specifically provides that it does not indemnify for "any

[1] Complaint Paragraph Six (4), and Paragraph Seven (4).

condition which was in existence prior to the effective date of this policy." Respondent's representations in this regard are incomplete and at variance with the policy provisions and, therefore, are deceptive and misleading.

(520)

The appeal of counsel supporting the complaint should be granted. An order modifying the initial decision in accordance with the foregoing considerations and including an order to cease and desist in conformity with this opinion will be entered in lieu of the order of dismissal by the hearing examiner.

April 19, 1957

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(521)

[Caption omitted]

Concurring Opinion of Chairman Gwynne and Commissioner Tait

It is our view that the Commission has jurisdiction herein for the reasons outlined in the concurring opinion in Travelers Health Association, Docket 6252, and the dissenting opinion in North American Accident Insurance Company, Docket 6456. It also should be noted that the respondent here admits the jurisdiction of this Commission.

The order should be limited accordingly.

April 19, 1957

TESTIMONY, EXHIBITS, PROCEEDINGS BEFORE THE HEARING EXAMINER, AND INTERLOCUTORY MATTERS

Commission Exhibit 1

(522)

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY
AMERICAN LIFE BUILDING — 3805 LINDELL BOULEVARD
ST. LOUIS 8, MO.

Hospitalization Department

43,000 persons who are well today
will be hospitalized tomorrow.
(Statistics show these figures)

Dear Friend:

Your interest in sending for information about our new PROVIDER POLICY is appreciated and I enclose herewith complete descriptive material.

During our long experience in the hospitalization field we have found that hospital and surgical costs have greatly increased in the last few years . . . In many cases as much as 100%. If you now have hospitalization insurance the chances are that it will not cover in full all the expenses involved should you have the misfortune of being hospitalized. If you do not have hospitalization insurance, then naturally you will have to pay all of the expenses out of your own hard earned dollars.

ACCIDENT AND SICKNESS GIVE NO WARNING!!!

Our brand New Provider Policy will pay you benefits while you are hospitalized for one day, one week, one month or one year if your doctor tells you to stay that long. (Government Hospitals excepted.) The policy goes into effect immediately, from the first day of hospital confinement for either sickness or accident, except in the case of sickness requiring a surgical operation, then the usual six month waiting period applies.

In addition, the policy will pay you benefits for 64 surgical operations, as well as benefits for ambulance, blood transfusion, oxygen tent, and rental of wheel chair or crutches. And that it not all: There is also a lump sum benefit $2,500.00 for loss of life due to travel accident by land, water or air. Child Birth Benefit may be added for only a few cents a month.

POLIO benefits are provided in lieu of other indemnity in a maximum amount of $3,287.50, covering such specific expenses as $7.50 per day for Hospital room, board and general nursing care for as long as 365 days. Doctor or osteopath expense while hospitalized for polio, $250.00; orthopedic appliances, $250.00; ambulance, rail or air travel expense to hospital $50.00

May I ask you, where can you get all these benefits for only 3c per day? (Even less than that for each member when the whole family is insured.) Our belief is that for this low cost we offer you the best contract money can buy.

I should also like to point out to you that all benefits included in this policy are payable regardless of any other insurance you may now have except Workmen's Compensation.

Act today—tomorrow, be glad you did. Fill out the enclosed applicati n right now and mail it in the enclosed envelope which does not need postage. Be sure to include all members of your family. Your policy will be sent immediately and if for any reason whatsoever you are not entirely satisfied, return it within 10 days, and all premiums paid will be promptly refunded to you. You have nothing to lose.

This wonderful new protection is too good to miss, so mail your application right now!

Sincerely,

s S. B. Hunt
President

SBH:a

Commission Exhibit 2

HELP TO AVOID *Crippling Expense*

LOW COST PROVID[illegible]

You Get Cash Regardless of any Payments from Other Insurance, except Workmens' Compensation.

Premium Refund Agreemen

We hereby guarantee that if the Provider Hospital-Surgical Policy issued to you by the American Life & Accident Insurance Company is not satisfactory in every respect you may return it within ten days from the date you receive it and the entire amount of the premium which you paid will be immediately refunded without question. You are the sole judge

DON'T WAIT . . . TOMORROW MIGHT BE TOO LATE!

Think back and look around at friends, neighbors and relatives. How often have you heard someone say "I wish I had done this or that and I would have been better off."

"Don't let wishing catch you asleep. Act now and be prepared." Accidents and sickness give no warning. And it's never convenient to pay out money for operations, ambulance fees, hospital room and board, etc. Many families have taken years to catch up financially just because they didn't have adequate insurance. If you have hospitalization insurance now, add to your protection with this new PROVIDER POLICY. Remember, it pays full benefits as outlined in the policy IN ADDITION to any other insurance benefits paid you, except Workmen's Compensation. Be sure you have enough money to meet your obligations when sickness or accident hits YOU. MAIL YOUR APPLICATION FOR THE NEW PROVIDER POLICY TODAY.

NOTE: For those who want it, a Maternity rider is available at small additional charge. Confinement in Government hospitals or any Institution that is not equipped with a laboratory, operating room, and Registered Nurse, always on duty, are not covered. Sickness resulting in surgery is covered if the cause originates after policy has been in force six months.

One Full Year Hospital Room Benefits

Every day of the year over 43,000 persons enter some hospital in the United States. You never can tell, tomorrow, it may be you or one of your loved ones. The NEW PROVIDER HOSPITALIZATION PLAN helps you pay for these emergencies, and you get benefits for hospital room and board for one day, one week, one month or a whole year.

You pay no extras . . . only 3¢ a day

YOUR ONLY COSTS

	Monthly	3 Months	6 Months	12 Months
Individual Adult (18 to 65)	$1.00	$ 3.00	$ 5.75	$11.00
Husband and Wife	2.00	6.00	11.50	22.00
Husband, Wife and One Child	2.75	8.25	15.80	30.25
Husband, Wife and Two Children	3.50	10.50	20.15	38.50
Either Parent and One Child	1.75	5.25	10.05	19.25

For each additional child under 18, add 75¢ per month.

YOU GET $5.00 TO $1,825.00

If sickness strikes and you enter any hospital, you will receive actual expenses not to exceed $5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year.

YOU GET $5.00 TO $1,825.00

If accident strikes and you enter any hospital, benefits begin at once. You will receive actual expenses not to exceed $5.00 per day for hospital room, board and general nursing care. These benefits are paid for one day, one week, one month, or a whole year.

YOU GET $5.00 TO $100.00

For surgical operations you get from $5.00 to $100.00 to help you pay your surgeon while hospitalized. There are 64 operations listed in the Schedule of Operations.

YOU GET $10.00

Should you require an ambulance for transportation to a hospital your NEW PROVIDER HOSPITALIZATION POLICY will pay actual expense incurred for AMBULANCE not to exceed 10.00

YOU GET $10.00

If you suffer ACCIDENTAL INJURY not requiring hospital confinement but emergency hospital treatment, the NEW PROVIDER HOSPITALIZATION POLICY will pay for such treatment not to exceed $10.00.

ADDITIONAL CASH PAID

The NEW PROVIDER HOSPITALIZATION POLICY provides additional payments incurred for services listed below but not to exceed the amount shown during any one confinement.

BLOOD TRANSFUSION **$25.00**
OXYGEN TENT **$10.00**
RENTAL OF WHEEL CHAIR or CRUTCHES ... **$10.00**

YOU GET $2500.00

THE NEW PROVIDER HOSPITALIZATION POLICY pays your beneficiary in lieu of other benefits $2,500.00 for death as a result of accident while traveling on a common carrier by land, water or air.

YOU GET $7.50 TO $2737.50

POLIO BENEFITS. Hospital room, board and general nursing care expense incurred not to exceed $7.50 per day from one day to a whole year.

YOU GET $250.00

To help you pay for expenses incurred for physicians or osteopaths while hospitalized for polio.

YOU GET $250.00

To help you pay for orthopedic appliances expense while hospitalized for polio.

YOU GET $50.00

To help you pay for ambulance, rail or air travel expense incurred to take you to hospital.

These polio benefits will be paid in lieu of all other benefits provided by this policy.

The AMERICAN PLAN

Pays You Generous Cash Benefits for HOSPITALIZATION DUE TO EITHER SICKNESS OR ACCIDENT IN EVERY STATE OF THE UNION AND SOME FOREIGN COUNTRIES

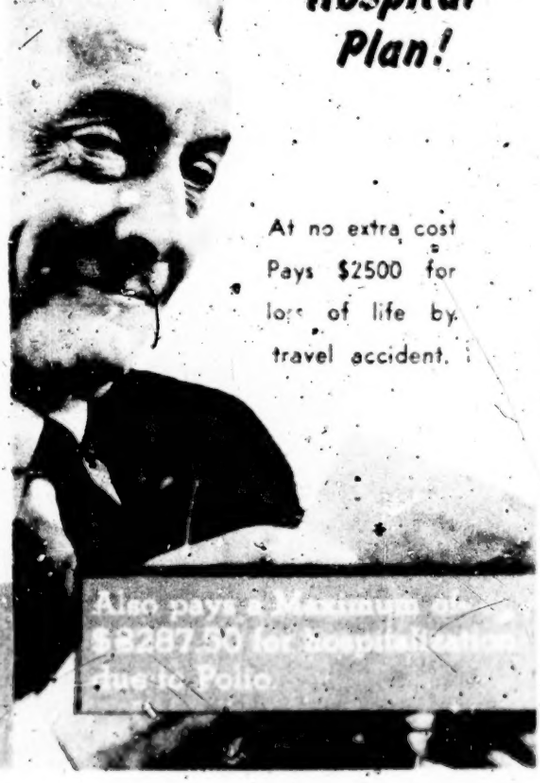
Don't Take a Chance

ACCIDENT AND SICKNESS GIVE NO WARNING

You may buy with confidence from the American Life & Accident Insurance Company who for over a quarter of a century has faithfully served its policyholders throughout the nation. The many testimonial letters from our members who have received cash benefits prove the wisdom of becoming a member of the "American Plan"

Over $700,000.00 in Government bonds and approved securities deposited with Division of Insurance, Department of Business and Administration for protection of policyholders wherever they may live.

Just 3¢ a day for a most Liberal Hospital Plan!



At no extra cost Pays $2500 for loss of life by travel accident.

Also pays a Maximum of $2287.50 for hospitalization due to Polio

AMERICAN

Life and Accident Insurance Company

AMERICAN LIFE BLDG. • ST. LOUIS 6, MISSOURI

Don't Delay!

MAIL YOUR APPLICATION TODAY FOR THE New Provider Policy

Individual and Family Groups from Birth to 65 Years of Age Are Eligible to Apply for This Policy

Enroll Now ..... Before it is too late!

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Commission Exhibit 4

GIVE THIS EXTRA APPLICATION TO A FRIEND

Application FOR THE *NEW*

Provider HOSPITALIZATION POLICY

NUMBER	CASH	PREMIUM	DATE	

PLEASE DO NOT WRITE IN THESE SPACES

American Life & Accident Insurance Company
St. Louis, Missouri

I hereby apply for a Hospitalization Policy in the American Life and Accident Insurance Company for myself and my dependents, if any, whose names appear below.

I represent to my best knowledge that all persons named are in good health and that there is no existing condition which may require either Hospitalization or Surgical operation, except as follows:

I further represent to my best knowledge that all persons named are under 90 years of age (husband or wife), and that all dependent minors are under 18 years of age, and are related to me in the following capacity: husband, wife, son, daughter, stepchildren, legally adopted son or daughter, or legally appointed guardian of minor children.

PLEASE PRINT OR TYPEWRITE THE FOLLOWING INFORMATION

NAME OF EACH PERSON TO BE INSURED	AGE	DATE OF BIRTH			WEIGHT	HEIGHT	
		MONTH	DAY	YEAR		Ft.	Ins.

IN EVENT OF ACCIDENTAL DEATH, BENEFITS ARE TO BE PAID TO—

Beneficiary | Relationship | RACE OR COLOR

Sign Here X

Signature of Applicant

IMPORTANT

Fill in, sign and mail with at least one month's premium.

Dated this _____ day of _____ 19__

Street and Number

City, Zone and State

Form 380 Rev 10-53

SCHEDULE OF PREMIUM

FOR MEN AND WOMEN UNDER AGE 65

PAY ANNUALLY **SAVE 1 MONTH**	1 Month	3 Months	6 Months	12 Months
One Person Only (Man or Woman) *(adults must be under 65 years of age)*	$1.00	$3.00	$5.75	$11.00
Man and Wife *(adults must be under 65 years of age)*	2.00	6.00	11.50	22.00
Either Parent and 1 Child *(child must be under 18 years of age)*	1.75	5.25	10.05	19.25
For each additional child UNDER 18 years of age—ADD	.75	2.25	4.30	8.25

Persons over age 65 and up to 75 can be insured when included with younger members of the family.

RATES SHOWN BELOW FOR SENIOR PROVIDER POLICY

PAY ANNUALLY **SAVE 1 MONTH**	1 Month	3 Months	6 Months	12 Months
65 years to 70	$1.50	$4.50	$8.65	$16.50
70 years to 75	2.00	6.00	11.50	22.00

The "Senior Provider Policy" will be issued to men and women age 65 and over —will pay Hospital Room and Board benefits not to exceed 30 days in any one year.

1. The name of each person to be insured must be listed in the application. The person signing the application must be included.
2. Be sure to include the premium for at least one month. You can pay quarterly, semi-annually or annually if you wish.

PREMIUM REFUND AGREEMENT

We hereby guarantee that if the Provider Hospital-Surgical Policy issued to you by the American Life & Accident Insurance Company is not satisfactory in every respect, you may return it within ten days from the date you receive it and the entire amount of the premium which you paid will be immediately refunded, without question. You are the sole judge.

L. B. Blunt
President

MAIL THIS APPLICATION NOW!

Commission Exhibit 3

(527)

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY

American Life Building—3805 Lindell Boulevard
St. Louis 8, Mo.

Hospitalization Department

Dear Friend:

Will you allow me to suggest that right now you take action in a matter of such great importance as Hospitalization Insurance? We know you would not have written us unless you were seriously interested, but we also know that many of us are inclined to let important things slide. Please don't do that. Don't gamble with the unforeseen.

Within the next hour more than 1700 persons will be hospitalized. Just think how few of them knew a few days ago what was in store for them. No one likes to go to the hospital; no one willingly becomes ill or involved in an accident. But these things do happen. They give no warning. And if sickness or accident should strike you or your loved ones, are you prepared to defray the present high cost of hospitalization?

If you now have hospitalization insurance, add our New "Provider" Policy to your present protection. If you do not have hospitalization insurance, then you must act quickly. Please don't read this letter as just so many words. Think seriously about what I am saying. It is for your own good, and I mean this from the bottom of my heart. Let's consider again the key points and wonderful advantages of our New "Provider" Policy:

#1. Benefits for hospital room, board and general nursing care for one WHOLE YEAR—not limited to 30 or 60 days as some other plans.

#2. Benefits do not reduce because of age.

#3. Benefits are paid regardless of any other insurance you may carry, except Workmens' Compensation.

#4. Policy goes into effect immediately for both sickness and accident; and pays for sickness requiring a surgical operation after the policy has been in force six months.

#5. SPECIAL POLIO BENEFIT, maximum $3,287.50 in lieu of other indemnity paid for hospital confinement.

#6. Pays $2,500.00 lump sum benefit for travel accidental death, at no extra cost.

#7. Children under 18 receive full benefits even though they do not pay full adult premium.

#8. Cost only 3¢ a day for adults (men and women). 2½¢ a day for children.

Yes, these are just a few of the many advantages you will enjoy under the New "Provider" Policy. There are still others which you will read about in the enclosed circular.

Won't you please GET BUSY AT ONCE and mail your application now? An envelope is enclosed for your convenience; it does not need postage. When you receive your policy, and if for any reason you are not fully satisfied, you may return it within 10 days and your money will be promptly refunded. You have nothing to lose. Mail your application Now!

Sincerely,

s/ S. B. Hunt
President

SBH:b

Commission Exhibits 8 and 9

(542)

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY

American Life Building—3805 Lindell Boulevard
St. Louis 8, Mo.

Hospitalization Department

Dear Friend:

A few weeks ago I mailed you literature describing our brand new Provider Hospital-Surgical Policy. As yet, however, I have not been favored with your application for this liberal, low-cost protection. Needless to say I am indeed disappointed. Why?

Because, to celebrate our company's 25th Anniversary we created this remarkable policy, and as head of this organization, I am vitally interested in seeing that this offer is well accepted by all of you who have inquired about it. Now you can understand why I am disappointed about not having heard from you.

Perhaps you already have hospitalization insurance. That's fine, but let me point out to you that our New Provider pays you cash regardless of any benefits you may receive from similar coverage, except Workmens' Compensation. This means that you can add our policy to your present protection to help you meet today's higher costs of hospitalization.

There are many other good reasons why you should apply now for the New Provider, and here are some of the reasons:

1) The New Provider goes into effect immediately, from the first day of hospital confinement, for both sickness and accident; and pays for sickness requiring a surgical operation after the policy has been in force six months. There is no reduction in benefits, ever. Even children who pay a lower premium receive full benefits, just like an adult.

2) Hospital room, board and general nursing care benefits are paid for one day, one week, one month, or one year if your doctor tells you to stay that long.

3) This policy also provides benefits to help you pay your surgeon's bill. There are 64 specific surgical operations listed in the policy.

FOR POLIO—THE DREADED DISEASE

4) SPECIAL POLIO benefits are provided in lieu of other indemnity in a maximum amount of $3,285.00, covering such specific expenses as $7.50 per day for Hospital room, board and general nursing care for as long as 365 days. Doctor or osteopath expense while hospitalized for polio, $250.00; orthopedic appliances, $250.00; ambulance, rail or air travel expense to hospital $50.00.

5) At no extra cost your beneficiary will get a lump sum cash payment of $2,500.00 for loss of life due to accident while traveling on a public conveyance over land, water or by air.

(see reverse side)

(541)

6) Unlike many other policies, the New Provider defines a hospital as any institution that is equipped with an Operating Room, Laboratory and a Registered nurse on duty, no matter where located. Only Government hospitals which do not generally charge you are excepted. Examine other policies and you may see a great difference. I point this out to you simply to indicate the possibility that under some policies many cases of confinement are not covered due to their definition of "hospital". Our definition is broad.

Read the enclosed circular and you will find there are more benefits besides the ones I have outlined, and all for only 3¢ a day for adult men and women, and only 2½¢ for

children under age 18. Where can you find a more liberal protection plan for yourself and your loved ones for such a low cost?

Allow me to explain to you that we have been pioneers in the field of Hospitalization Insurance, and also that this policy has been carefully planned. In fact when we designed this contract to celebrate our company's 25th Birthday we had in mind two things:

(1) The most liberal, (2) at the lowest cost possible.

Please think this over carefully, thoughtfully. If you do this you will no doubt decide you should have hospitalization insurance such as the New Provider, even if you now have some other policy. Don't put it off until tomorrow—apply now and don't be sorry later.

Fill out and sign the enclosed enrollment form today.

Sincerely,

s/ S. B. HUNT
S. B. Hunt
President

SBH:c

P.S. Remember our policies are sold under a rigid premium Refund Agreement; should you be dissatisfied with the policy for any reason whatsoever, you may return it within 10 days and we will refund your initial payment.

Commission Exhibit 10
(identical with Commission Exhibit 18)

(543)

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY

American Life Building—3805 Lindell Boulevard
St. Louis, Mo.

Hospitalization Department

Dear Friend:

Will you do me a personal favor?

A few weeks ago, you inquired about our NEW PROVIDER Hospitalization policy. Your inquiry was answered promptly, and again and again I wrote you explaining the many advantages of this low cost protection. Since I have not been honored with your reply, I am inclined to believe that I have fallen down on the job. How, I do not know. Will you tell me?

I think the NEW PROVIDER policy, for the small premium charged, is the best insurance value on the market today. Now then, if you have other hospitalization insurance, I want you to know that our policy will pay you cash benefits regardless of any other insurance you may have covering the same loss, except Workmen's Compensation. Also, remember that hospital costs have been going up continually and it is wise to add to your present protection the liberal benefits offered by the NEW PROVIDER. Of course, if you do not have other hospitalization you should by all means, apply right now for the NEW LOW COST PROVIDER POLICY.

May I ask you again to read the enclosed circular which describes in clear-cut language the many benefits provided by this policy? Please note these important facts:

Policy goes into effect immediately; from first day of hospital confinement, for both sickness and accident; and pays for sickness requiring a surgical operation after the policy has been in force six months.

Pays full benefits from first day of hospital confinement for either sickness or accident, from one day to one year. (Government Hospitals excepted.)

Benefits are not reduced because of age; children receive same benefits as adults, but pay less premium.

SPECIAL POLIO BENEFIT, maximum $3,287.50 in lieu of other indemnity paid for hospital confinement.

Where could you get this same protection at such low cost? I suggest you mail the enclosed application right now. You have nothing to lose. Should you be dissatisfied with the policy for any reason whatsoever, you may return it within ten days from the day you receive it and the initial payment will be promptly refunded in full.

The time to act is now! Mail your application today.

Sincerely,

s/ S. B. HUNT
President

SBH:d If you are one of our Policyholders, kindly pass this literature to a friend or relative who may be interested in Hospitalization Insurance. Thank you.

Commission Exhibit 16

(558)

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY

American Life Building—3805 Lindell Boulevard
St. Louis 8, Mo.

Hospitalization Department

Dear Friend:

Ever hear of an insurance company advertising what its policy does NOT cover. Well, here is what the new PROVIDER policy does not cover:

(a) any sickness or injury which was in existence before the policy was taken out, (b) maternity or any complication of childbirth unless 50¢ per month extra premium is included, (c) insanity, mental or nervous diseases, (d) while in the Army or Navy, (e) any sickness which requires a surgical operation unless the sickness begins six months after the policy is issued, (f) suicide, (g) confinement in a Government hospital, (h) Workmens' Compensation cases, (i) violation of the law, (j) when under the influence of alcohol or narcotics unless administered on advice of a physician.

The Exceptions and Limitations described above are printed in BOLD FACE type on the second page of the PROVIDER policy.... No fine print. We want our policy owners to know what their policies do not cover as well as what they do cover. You may buy the PROVIDER policy with full confidence that it covers within its limits every disease or injury which is not mentioned in the indented paragraph above.

In a more personal vein, I realize that this may not be the conventional way for an insurance man to sell his policies. Actually it is much more pleasant for me to tell you, as I have before, of the many liberal benefits you will receive under the PROVIDER policy than it is to tell you what the policy does not cover. On the other hand, I feel it is my duty and an obligation to explain the few reasonable exclusions which you will find are quite standard with most hospitalization plans.

Now please read the enclosed circular and learn what the PROVIDER policy will do for you.... then deduct from it the exclusions quoted above. Result: A sales presentation which is as honest as we know how to make it.

Send in your application today. Get your PROVIDER policy and peace of mind along with it.

May I hear from you please? Mail your application today.

Sincerely yours,

s/ S. B. HUNT
S. B. Hunt
President

SBH:f

P.S. If you are one of our Policyholders, kindly pass this literature to a friend or relative who may be interested in Hospitalization Insurance. Thank you.

Commission Exhibit 22

(574)

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY

American Life Building—3805 Lindell Boulevard
St. Louis 8, Mo.

Hospitalization Department

Dear Friend:

For the eighth time your postman has delivered to you a letter from your friends of the AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY. We don't want to annoy you with our letters if you are not interested in what we have to say. On the other hand, we don't want to ignore you or your inquiry of a few months ago. At that time you had a genuine interest in our NEW PROVIDER HOSPITALIZATION policy. In the meantime that interest has grown and you have failed to do anything about it, or it has waned for some unknown reason to us. In either case, we would like to hear from you.

Let's get real chummy, shall we? By this time we feel that we have kindled a friendship that we don't want to lose. If you are inclined to feel that way too, lets make the friendship steadfast. We can do that by adding your

MEMBERSHIP to our friendly organization—not just for the sake of friendship, but for the protection of you and your loved ones in time of need. Should the time ever come for you or some member of your family to be hospitalized for sickness or accident, we would like to be right there with you with our NEW PROVIDER to help you financially in time of need. Peace of mind in time of trouble is an all important factor. We can also share that comfort, with your membership, knowing that we may be called upon sometime to help you. The old adage, "A FRIEND IN NEED IS A FRIEND INDEED" is a familiar saying, often times spoken without meaning. We would like to prove the importance of that proverb by having the opportunity to serve you.

In previous correspondence to you, we have explained carefully the many benefits offered by the NEW PROVIDER policy—also just exactly what the policy does not cover. This should prove our straightforward method of doing business. We gave you a brief sketch about our twenty-five year old stock company, which is well known and reliable. We also told you about our prompt and courteous service in adjusting claims and that we have deposited over $700,000.00 with the Insurance Department to protect our policyholders wherever they may live. Frankly speaking, we believe you should know us quite well by now; however, if you have any questions to ask, you may use the reverse side of this letter and the postage-frid [sic] envelope enclosed.

We are again enclosing descriptive literature, also calling your attention to a few important facts which you may have overlooked. There is no reduction of benefits for minors or for older persons. The premiums are NOT increased because of age (except in the case of children when they attain age 18) nor is the policy ever cancelled because of age. Hospital room, board and general nursing care benefits are paid for one day and up to one year if you have

to stay that long. Persons up to age of ninety are eligible (Please refer to the slip enclosed marked "Important.")

Sincerely,

s/ S. B. HUNT
President

SBH-H
Enclosures

Commission Exhibit 27

(588)

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY

American Life Building—3805 Lindell Boulevard
St. Louis, Mo.

Dear Friend:

Thousands of people throughout the United States have heard about the new PROVIDER Hospital-Surgical Plan. THOUSANDS HAVE BECOME MEMBERS!

Why? They realized they could not invest a few cents a day to better advantage.

The new Provider pays hospital room, board and general nursing care from one day up to 365 days for any one sickness or accident. The Policy goes into effect immediately, from the first day of hospital confinement for both sickness and accident, and pays for sickness requiring a surgical operation after the policy has been in force six months.

IMPORTANT

There is a shortage of doctors. Many doctors simply do not have time to make home calls or keep long office hours. Here is what the doctor shortage may mean to you: The very next time you or a member of your family becomes ill, the doctor may decide to send you to a hospital where he has many patients, and thus can treat you and the others under one roof.

Thanks to the untiring efforts of the medical profession most of us today enjoy better health, yet you are much more likely to be hospitalized now-a-days than ever before.

SPECIAL POLIO BENEFITS: The New Provider pays 50% additional hospital room, board and general nursing care benefits in the event you are stricken with the dreaded disease polio. In other words it pays $7.50 per day instead of $5.00, up to $3,287.50 while in hospital, including $250.00 for doctor, $250.00 for orthopedic appliances and $50.00 for ambulance, rail or air travel to hospital.

Even if you already have hospitalization protection, you will be wise to take the PROVIDER too. It pays benefits in addition to and irrespective of any other similar insurance you may carry. An extra safety cushion.

In the enclosed circular we have tried to boil down in simple, everyday language just what the PROVIDER will do for you and your family when the day comes for that trip to the hospital and during the days of difficult financial strain to follow.

Send in your application right now, while it is still fresh in your mind. The self-addressed envelope needs no postage and you will get your PROVIDER policy within a few days by mail. It will be in full force when the mailman delivers it to you.

Sincerely,

s/ S. B. Hunt
President

SBH:i

P.S. If you are one of our Policyholders, kindly pass this literature to a friend or relative who may be interested in Hospitalization Insurance. Thank you.

Commission Exhibit 42

(626)

INCORPORATED UNDER THE LAWS OF THE STATE OF MISSOURI

This policy provides indemnity for loss of life by accidental bodily injury, or for hospital and surgical expenses on account of sickness or accident, as herein provided. This policy is renewable at the option of the company only.

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY
ST. LOUIS MISSOURI

A STOCK COMPANY

(Hereinafter Called The Company)

HEREBY INSURES each person named in the Schedule on Page Four hereof, hereinafter referred to as the insured or insured family and subject to all provisions and conditions hereinafter contained.

1. HOSPITAL ROOM, BOARD AND GENERAL NURSING CARE EXPENSE incurred not to exceed Five Dollars ($5.00) per day, maximum $1,825.00
The Company will pay any insured member listed herein when hospitalized as a resident patient for one day or longer due to either sickness or injury, benefits for actual expense incurred for hospital room, board and general nursing care at the rate of Five Dollars ($5.00) per day for the period of such confinement not to exceed Three Hundred Sixty Five (365) days (Government Hospital excepted).

(1. a) EMERGENCY HOSPITAL TREATMENT FOR ACCIDENTAL INJURIES. Should the Insured sustain accidental bodily injury requiring treatment in a hospital, the Company will pay the charges of the hospital, but not to exceed Ten Dollars ($10.00) for each accident not requiring hospital confinement.

2. SURGICAL OPERATIONS. The Company will pay benefits for Surgical Operations performed by a legally qualified

physician or osteopath while the Insured is confined as a resident patient in a hospital, for and in amounts set out in the Schedule of Surgical Operations on Page Two herein.

TRAVEL ACCIDENTAL DEATH IN PUBLIC CONVEYANCE INCLUDING AIR TRAVEL	$2,500.00

3. POLIO BENEFITS HOSPITAL ROOM, BOARD AND GENERAL NURSING CARE EXPENSE incurred not to exceed Seven Dollars Fifty Cents ($7.50) per day — Maximum $2,737.50

PHYSICIAN OR OSTEOPATH EXPENSE incurred while hospitalized	250.00
ORTHOPEDIC APPLIANCES EXPENSE incurred hospitalised	250.00
AMBULANCE, RAIL OR AIR TRAVEL EXPENSE incurred to hospital	50.00

Benefits stated in Paragraph 3 shall be payable for a period not to exceed Three hundred and sixty-five (365) days (*Government Hospital excepted*), and shall be in lieu of all other indemnity provided herein.

4. The privileges, benefits and conditions stated on the following pages, form a part of the contract as fully as if recited over the signatures hereto affixed.

5. IN WITNESS WHEREOF, The American Life and Accident Insurance Compny has caused this Policy to be signed by its President and Secretary, at St. Louis, Missouri.

/s/ F. J. Moran
Secretary

/s/ S. B. Hunt
President

This Policy is issued in accordance with the Provisions of the Stipulated Premium Law, Sections 377.200 through 377.460, Revised Statutes of Missouri, 1949.

Form 632 4-52

(627)

[Page Two] 6. TRAVEL ACCIDENTAL DEATH. If death of the Insured shall result solely from accidental bodily injury within 90 days after such injury, while riding as a fare paying passenger in any public conveyance including a licensed passenger airplane provided by an incorporated common carrier of passengers and while operated by a licensed transport pilot upon a regularly scheduled passenger route between definitely established airports, the Company will pay *in lieu of all other indemnity*, Travel Accidental Death Benefit of Twenty-Five Hundred Dollars ($2500.00).

7. AMBULANCE EXPENSE. The Company will pay the actual expense in connection with the service of an ambulance to transport the Insured to a hospital for any condition for which benefits are payable under Paragraph 1, but not to exceed Ten Dollars ($10.00) in connection with any one hospital confinement.

8. ADDITIONAL INDEMNITY. Should indemnities be payable on account of hospital confinement as set forth in Paragraph 1, the Company will pay additional indemnity covering the actual expense incurred for the services listed below, but not to exceed the amounts shown, during any one confinement.

BLOOD TRANSFUSION	$25.00
OXYGEN TENT	10.00
RENTAL OF WHEEL CHAIR OR CRUTCHES	10.00

9. GRACE PERIOD. If any premium is not paid on or before the date it falls due, the Insured is in default; but a grace of one month (not less than thirty days) without interest charge will be allowed in the payment of every premium after the first, during which time the insurance continues in force.

10. Power of Attorney for Service of Process. This Company has on file with the Superintendent of the insurance Department of Missouri, at Jefferson City, a power of attorney, irrevocable for its term, authorizing said Superintendent to accept and acknowledge service of process in a court of record and under the laws of another State where the Company is not deprived of its right to defend the case on its merits when such process through service official, in duplicate, is transmitted to said Superintendent by registered United States mail if limitations as to time to plead, etc., as provided in said power of attorney, are met. Said power of attorney is incorporated by reference in and made a part of this policy, whereby the Company acknowledges itself bound by said original power of attorney according to its limitations and provisions contained in the original on file with said Superintendent of the Missouri Insurance Department.

11. Schedule of Surgical Operations. Not more than one (the greater) of the amounts specified in the Schedule will be paid on account of any one sickness or injuries resulting from any one accident, and then only if the Insured is hospitalized as a resident patient.

Amputation	
Arm	50.00
Forearm	50.00
Hand	50.00
Finger or Fingers (at least one entire phalanx)	10.00
Leg	50.00
Thigh	50.00
Foot	50.00
Toe or Toes (at least one entire toe)	10.00
Appendix	
Removal of	25.00
Abscess or Cellulitis	
Incision or incisions	$ 5.00

BONE—Disease of or injuries to Removal of portion of Bone	10.00
CANCER—(Except of skin) Removal of, by cutting operation	35.00
CHEST—Cutting into thoracic cavity for diagnosis or treatment of organs therein (except tapping)	40.00
DISLOCATION	
Open Reduction of Hip or Knee (Patella excepted)	30.00
Patella	5.00
Open Shoulder, Elbow, Wrist or Ankle	20.00
Lower Jaw	10.00
Thumb	5.00
Finger or Fingers	5.00
Toe or Toes	5.00
EYE	
Removal of Eye	$50.00
Removal of Cataract	35.00
FRACTURES, REDUCTION OF	
Lower Jaw	25.00
Collar Bone	25.00
Shoulder Blade	30.00
Nose, Breast Bone or Ribs	10.00
Upper Arm	20.00
Forearm	20.00
Hand	20.00
Finger or Fingers	10.00
Bones of the Pelvis, ~~except Coccyx~~	30.00
Coccyx	15.00
Thigh	50.00
Knee Cap or Leg	25.00
Bones of Foot	25.00
Toe or Toes	10.00

Gall Bladder	
Complete removal by Cholecystectomy	40.00
Removal of Stone or Stones	40.00
Gunshot Wounds	
Treatment of	15.00
Hydrophobia	
Pasteur Treatment	50.00
Kidney	
Removal by Nephrectomy	60.00
Lockjaw	
Injection of Antitoxin into skull	40.00
Injection of Antitoxin into Spinal Canal	20.00
Nerve	
Cutting operation for stretching	20.00
Mastoiditis	
Cutting operation for removal of diseased bone	25.00
Rectum	
Entire removal (Amputation)	60.00
Prolapsed Rectum Excision	30.00
Skull	
Cutting into Cranial Cavity	100.00
Stone in Urinary Bladder	
Removal of, by cutting operation	40.00
Removal by Cystoscope	20.00
Spine or Spinal Cord	
Operation with removal of fractured vertebra, except Coccyx	50.00
Removal of Coccyx	30.00
Stricture	
Cutting operation (external) for Esophagus	75.00

Tapping of	
Abdomen	$10.00
Bladder	10.00
Chest	10.00
Ear Drum	5.00
Joints	5.00
Thyroid	
Removal by Thyroidectomy	30.00
Tonsils or Adenoids	
Removal of	15.00
Tumors	
Removal of by Cutting Operation:	
Malignant	35.00
Benign	10.00
Veins	
Varicose cutting operation	15.00
Injection operation	10.00

EXCEPTIONS AND LIMITATIONS

This policy does not provide indemnities for (a) any condition which was in existence prior to the effective date of this policy or at the time of any reinstatement; (b) pregnancy, childbirth or any complications thereof; (c) treatment of mental disease or derangement or nervous ailments; (d) any loss caused by war or any act of war, or while in military or naval service of any country at war. Any premium paid to the Company for any period during which the Insured is in military or naval service of any country at war, will be returned upon request. (e) Any sickness which requires a surgical operation unless such sickness has its origin after the expiration of six months from the effective date of this policy or last reinstatement; (f) suicide or attempt thereat while sane; (g) confinement in a Government hospital; (h) injuries or

diseases for which benefits are provided under any Workmen's Compensation Law.

The Company shall not be liable for death, injury incurred, or disease contracted, to which a contributing cause was the Insured's commission of, or attempt to commit a felony, or which occurs while the Insured is engaged in an illegal occupation.

The Company shall not be liable for death, injury incurred, or disease resulting from the Insured being intoxicated or under the influence of alcoholics or narcotics unless administered on the advice of a physician.

* * * * * *

[Standard and General Provisions omitted]

(629)

[Page Four]

This policy provides indemnity for loss of life by accidental bodily injury, or for hospital and surgical expenses on account of sickness or accident, as herein provided. This policy is renewable at the option of the company only.

Space for Endorsements

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY
Incorporated,
St. Louis, Missouri

Substance of the Application
Which May Affect the Validity of
this Policy

THE PROVIDER
Individual or Family Group
Hospital-Surgical Policy

American Life & Accident
Insurance Co.
St. Louis, Mo.

I represent to my best knowledge that all persons named herein are in good condition mentally and physically and

that there is no existing condition which may require either Hospitalization or Surgical Operation, except as follows: No exception

I further represent to my best knowledge that all person's named herein are under 90 years of age (husband or wife), and that all dependent minors are under 18 years of age; that all those named are related to me in one of the following capacities; husband, wife, son, daughter, legally adopted son, daughter, stepchildren or that I am the legally appointed guardian of minor children.

(Schedule of Policy Information)

Policy No.
Effective date Schedule of Insured Members
Beneficiary:
Relationship:

S. Brad Hunt,

on behalf of the Commission, testified as follows (March 10, 1955):

[Tr. 175] * * * What, if any, factors are used then in determining whether or not that claim should be paid, as you sit in the underwriting committee?

A. The underwriting committee would have nothing to do with the payment of the claim.

Q. I mean the claim committee, I am sorry, sir.

A. The claim committee, I would say, would have nothing to do but to pay the claim if they carried it three years.

Q. You would not reject it?

A. No, sir, unless it came under one of the limitations of being in a government hospital, or for some one of the few things that we have filed exceptions to.

Q. What are some of the few things?

A. The law requires us to set them out in bold type in the policy.

Q. Have you ever rejected such claims before you read that based upon a condition, the policyholder, a condition

that existed within the policyholder prior to the time you issued the policy?

MR. LAYNE: Mr. Examiner, I don't understand the question.

HEARING EXAMINER COX: Maybe you don't have to if the witness does.

MR. SILLS: As a matter of fact, I would like to [Tr. 176] rephrase it.

By MR. SILLS:

Q. You have a claim before you. You are now in the claim committee room. This man has been a policyholder for three years.

A. Yes, sir.

Q. He has filed a claim for hospitalization expenses as a result of a sickness. If it were shown that this sickness was traceable to a cause or a condition that existed prior to the effective date of the policy, would you reject the claim?

A. That would be a question for the policy contract, Mr. Sills.

Q. That is what I am asking you. What is the policy?

A. Here is our policy procedure.

Q. Yes.

A. If the insured applied and stated in his application he was in good health, and never had been treated and he files a claim and he had had some two or three strokes of paralysis prior to that time, and re-enters with maybe the third or fourth stroke of paralysis, this information comes in from his doctor and from his statement. Then the policy would exclude paralysis, notwithstanding the fact that he withheld the information when he applied. He did not give us his insurable condition. And of course, from a period of [Tr. 177] three years, I will say this: I have never known a case while the policy limits the liability on the preexisting conditions, in the 29 years I have been with American Life and Accident we have never had a case

like that that wasn't paid. We may not renew the policy but we paid those claims. The Missouri Department will verify it.

Q. How many claims did you disallow in the calendar year 1953, and I recognize I asked the question this morning. I ask it again.

A. I don't know.

Q. Yet you are sure that you never disallowed a claim for a pre-existing condition three years after the effective date of the policy?

A. Yes, sir.

Q. Have you ever denied one two years?

A. I don't think so.

* * * * *

[Tr. 178] * * * Q. May I ask you, then, what normally are the reasons or causes that you do reject a claim, and I will stay with the sickness for a moment. We will get to accidental injury later.

A. Again, it depends on proof of the claim, the proof that is furnished us, Mr. Sills, and the policy contract. We cannot reach up in the air and bring out an example. I cannot tell you and tell you the action. We have no set rule.

Q. But there are factors you consider?

A. Well, if a person misstates their health condition and if you say in your application you are in good health and no illness, after your policy is a few months old you file a claim, you give us a history in your claim blank that you have been sick for two years and the doctor states he has [Tr. 179] been treating you for that trouble for two years, that would make a question about the claim.

Q. Staying on that factor for just a moment, suppose it were determined that a condition had existed with the policyholder at the time he made this statement but he did not know it?

A. The claim would be paid.

Q. The claim would be paid?

A. Yes, sir.

Q. It has been paid in all instances?

A. Yes, sir.

Q. How do you determine whether or not he knew it or did not know it?

A. We ask him the question and again we rely on what he tells us and what his physician tells us. We have reason to believe he is truthful and he had no knowledge of his illness, we paid those claims.

Q. You are positive about that?

A. Yes, sir.

Q. What are some of the other factors?

A. You will have to mention the factor, Mr. Sills.

Q. You have already mentioned that some of the factors that enter into your mind and the minds of this committee and whether or not you are going to pay or reject a claim, one of which was whether or not he had truthfully disclosed his condition [Tr. 180] at the time he filed his application, about health. What are some of the others?

A. That is the principal one, of his insurability, when he submits his application, withholding his true condition.

Q. That is all?

A. Yes, sir.

Q. May I have that policy?

A. Yes, sir.

Q. I notice in your policy there is no definition of sickness or accident. You refer to injury. What is an injury within the meaning of this policy?

A. Well, so far as we are concerned, anything that causes him to go to the hospital, whether it is a dog bite or whether he falls down or anything that brings on a disability that requires him to be necessarily confined to the hospital.

Q. Must there be bodily injury?

A. Well, it don't necessarily have to have any evidence.

Q. How do you know whether he is injured or not?

A. We take the statement of his doctor, the hospital record.

Q. Does it make any difference in whether you pay the claim as to whether or not the accident or the cause of the accident was related to a condition of health?

A. You mean pre-existing the date of the policy, or any time?

Q. Pre-existing the date of the policy.

[Tr. 181] A. It would, if he knowledge of it.

Q. Let's assume he doesn't.

A. If he doesn't have knowledge of the illness or the injury, he is an innocent person; we would pay the claim.

* * * * * *

[Tr. 194] * * * A. We revalue the person's insurability when it comes up for renewal.

Q. What are the tests that you use?

A. Well, as I stated a little while ago, if we have paid a claim for a man in a bank holdup or a robbery, chances are his renewal would be denied. There are a number of reasons that you revalue the risk when that policy is renewed.

Q. How many policies did you cancel during the year 1953?

A. I would say it was very few; I don't know offhand.

Q. You have no idea?

A. No, sir.

Q. Would you say it was three or four percent of the outstanding policies?

A. Not more than that.

Q. It could be? Was it that figure?

A. It could be. I would say the highest I think we have ever run is possibly between two and three percent.

Q. Does it ever run below two and three percent?

A. Oh, yes; as low as half of one percent.

Q. Well, I am referring to the calendar year '53.

A. Well, there are months in '53 and '54 that it would run a very small percentage.

[Tr. 195] Q. Does the number "7" mean anything to you?

A. 700?

Q. Yes.

A. I don't know.

Q. Does it?

A. It depends on what it refers to.

Q. With reference to the cancellation of policies in the calendar year '53.

A. It could; it could be that many, not cancelled but non-renewals. We don't cancel.

Q. As far as the policyholder is concerned, he is cancelled?

A. Beg your pardon; that is renewal. Comes up for renewal.

Q. And he has sent his premium payment to you?

A. In some instances.

Q. And in some instances you return it to him?

A. Yes, sir.

Q. What do you tell him when you return it?

A. That the underwriting committee has declined to renew his policy.

Q. How many of those that you declined to renew were due to robbing a bank?

A. Well, I wouldn't know.

Q. Would you say it was half of them?

A. No, sir.

Q. Would you say it was more than one?

[Tr. 196] A. I wouldn't say because each individual case is handled on its own merits.

Q. How many policies were refused to be renewed by your company due to the commission of a felony?

A. I don't know.

Q. You have no idea?

A. No, sir.

Q. The reason I ask is you recited that twice as a paramount reason for failing to renew these and I assumed that was one of the major factors.

MR. LAYNE: He is arguing with the witness.

MR. SILLS: I am pointing out why I asked the question. Now may I ask this:

By Mr. Sills:

Q. Besides felonies, what are the other reasons you refused to renew a polic ?

A. Many times, Mr. Sills, we have received claims where the doctor would say that he knew that this condition had existed prior to the date of the policy, from his statement. The insured said they had no knowledge of their trouble. We pay the claim, as I stated before, but we wouldn't renew the policy; wouldn't be an insurable risk at that rate. That is one of the great reasons.

* * * * *

[Tr. 218] * * * Q. Mr. Hunt, you were asked the question with respect to the receipt of application forms on which the applicant had not indicated any physical condition or prior illness or prior treatment, medical treatment, and you indicated, I believe, in your testimony that where the application did not indicate such the company would ordinarily or usually issue a policy to the applicant, is that correct?

A. Yes, sir.

Q. Now, you were also asked whether, if some time subsequent to that time, the company learned in connection with a claim that the applicant had knowledge in fact of a pre-existing condition, or medical treatment for that condition prior to the application, whether or not the company would deny the claim.

In those cases, would the company deny the claim [Tr. 219] where the applicant had knowledge. Where the applicant had knowledge of his condition at the time the application was made but it was not indicated on the application form, would the company subsequently deny a claim?

A. We would deny the claim and return his premium.

Q. In those cases, such cases, where the applicant had knowledge and had made no indication on the application form, would the company in each case refund the premium?

A. Yes, sir.

Q. Did in fact the company refund the premium under those circumstances to your knowledge during the years 1953-54?

A. To my knowledge, with this one exception, Mr. Layne. Occasionally, we will have paid probably an accident claim or maybe two accident claims before we receive a health claim of several years' standing. That was not revealed in the application. In that case, the policy holder had already collected many times what he has paid in and there would be no refund premium in that instance because they had insured for the things that actually happened.

Q. In that situation, the company would have refunded the premium?

A. Would have refunded the premium.

Q. In connection with the pre-existing condition in conjunction with a claim that may later be asserted, must there be any relationship between the pre-existing condition and the [Tr. 220] claim later asserted in order to bring about a denial of the claim and refund of the premium?

A. Yes.

Q. What are they?

A. The insured must have knowledge of that pre-existing condition at the time he made his application.

Q. And what I am asking, though, what of the nature of the pre-existing condition in conjunction with the condition for which claims are now, claim is later asserted? Must there be a relationship between the pre-existing condition and the condition for which claim is made?

A. Definitely. It must be for the same condition.

Q. Well, if the pre-existing condition has no effect upon or relationship to the condition for which the claim is now made, does the company assert or deny claims under those circumstances?

A. No, sir; we would pay that claim because it had nothing to do with the pre-existing conditions.

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[Caption omitted]

Application for Release of Information

To the Federal Trade Commission:

1. This is an application, pursuant to Section 1.134 of the Commission's Rules of Practice and Procedure, by respondent in the above proceeding for the disclosure of certain records, files, papers, or information.

2. A description of the specific information, files, and documents inspection of which is requested is set forth in the Schedule attached hereto and made a part hereof.

3. A copy is sought of each of the documents described in the attached schedule; the copies are to be used as evidence by respondent in opposition to the complaint at the hearing in the above proceeding, now scheduled for November 21, 1955. Respondent respectfully requests that such copies be made available before that date.

4. For cause why such records, files, papers, and information should be disclosed, respondent shows as follows: The above proceeding is brought under Section 5 of the Federal Trade Commission Act and alleges that respondent

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has engaged in misleading or deceptive practices in that, by the use of certain literature, described in Paragraph Five of the complaint in the above proceeding, it has made certain representations, set forth in detail in Paragraph Six of the complaint, respecting its insurance policy known as the Provider policy, which are false in certain respects, set forth in Paragraph Seven of the complaint. The documents sought by this application all pertain to these allegations of the complaint, for the following reasons (the documents sought are described in the attached schedule in four numbered paragraphs, which are dealt with separately herein):

a. Paragraph 1(a) of the Schedule asks for the production of a card, which the respondent will present testi-

mony of its having signed, indicating receipt of or adherence to the Commission's Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance. The relevancy of this document is in connection with evidence that respondent expects to present, indicating that it adhered to and complied, throughout all relevant times, with the Trade Practice Rules. This evidence relates to respondent's contention that these rules sanctioned, or failed to forbid, the practices complained of by the Commission as unlawful. Cf. *Wildroot Company, Inc.*, Docket No. 5928 (decided June 30, 1953). The scope of the demand is limited to a single document. Paragraph 1(b) of the Schedule calls for correspondence covering the transmittal of the signature card between the company and the Commission, which is relevant to the issue of the Commission's knowledge of respondent's adherence to the Trade Practice Rules. Not more than two or three documents should be involved.

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b. Paragraph 2 of the Schedule contemplates the production of documents relating to the possible existence of complaints made by members of the public, either before or after the institution of this case, about respondent's literature or its policies, to the extent that these are now in issue in this case. In demanding documents dealing with complaints, respondent has included in the request two alternative methods by which the Commission may comply with the request without disclosing the identity of the persons complaining, thereby protecting any supposed privilege of the Commission. The complaints sought are those which discuss, with respect to respondent's Provider policy, or its predecessor, any of the provisions complained of in Paragraphs Six and Seven of the complaint as having been misrepresented. The demand is therefore restricted to complaints pertaining to the practices of which, as respondent understands the proceedings to date, the record contains evidence of possible deception. The relevancy of documents pertaining to public complaints lies in their

relation to two contentions of respondent: (1) the contention that, this case being one of first impression, and the Commission having had little or no experience with public complaints about the practices alleged to be unlawful, the Commission can lay no claim to administrative "expertise" in evaluating the practices; and (2) the contention that there is little or no public interest in the institution of this proceeding.

c. Paragraph 3 of the Schedule requests every copy of the Provider policy, and its predecessor, and every copy of each advertisement referring to these policies received

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by the Commission before the date on which respondent became aware of the Commission's general investigation of insurance. The documents demanded are limited to those in evidence to date, together with predecessor policies and literature of similar content to those in evidence. The relevancy of these documents lies in their relation to respondent's contention that the documents now in evidence, as well as documents containing statements identical or similar to those complained of by the Commission, were submitted to personnel of the Commission *ante litem motam*, and that the Commission was repeatedly made aware of the existence and content of the documents and was repeatedly given an opportunity to complain of their content, with reference to the Trade Practice Rules or otherwise. This contention, respondent submits, goes to the ultimate issue of public interest. Cf. *Argus Cameras, Inc.*, Docket No. 6199 (decided October 29, 1954). It also goes to respondent's contention that the Commission personnel whose opinions were most expert in the field regarded respondent's practices, here in issue, not unlawful. Duplicates of all documents are sought, where duplicates exist, in order to show the quantitative extent of respondent's submittals.

d. Paragraph 4 of the Schedule requests interoffice memoranda, and the like, made in the Bureau of Consulta-

tion, to the extent that such memoranda relate to the submittal of the policies and literature or to conferences about such documents between personnel of the Bureau of Consultation and counsel for the parties to the Trade Practice Rules. The purpose for which respondent seeks these memoranda is to show that respondent's policies and literature, including provisions and statements now alleged to

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be unlawful, were discussed with, found unobjectionable by, and approved by Commission personnel, with reference to the Trade Practice Rules and otherwise. This purpose again goes to the ultimate issues of public interest and of the opinion, as to the merits, of the Commission's most expert personnel. By limiting the request to documents of the Bureau of Consultation and its predecessors, respondent has sought to exclude work papers and memoranda made in view of the present litigation, thereby protecting any supposed privilege of the Commission.

5. Concurrently with the filing of this application, respondent is applying to the Hearing Examiner in the above case for a subpoena *duces tecum* directed to the Secretary of the Commission and calling for the production of the documents described in the attached Schedule. Respondent makes this application because it has reason to believe that counsel supporting the complaint will oppose the granting of or move to quash such subpoena, on the ground, among others, that the documents described are confidential under Section 1.133 of the Commission's Rules of Practice and Procedure. Respondent maintains that the documents requested may not be withheld without violating its rights under the Federal Trade Commission Act, the Administrative Procedure Act, and the Due Process Clause of the Constitution, and that, all of the documents or their contents having previously belonged to respondent or been disclosed to it by members of the Commission's staff, as described above, any privilege to withhold

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them has been waived. However, in the light of the expected claim of privilege, without waiving its position as

herein stated, respondent pursues the foregoing application in order to expedite the proceedings in the above case.

Respectfully submitted,

s/ A. Alvis Layne, Jr.
A. Alvis Layne, Jr.

s/ T. S. L. Perlman
T. S. L. Perlman
Attorneys for Respondent
Pennsylvania Building
Washington 4, D. C.

[Jurat omitted]

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SCHEDULE

1. (a) The signatory card, or writing, signed by American Life & Accident Insurance Company of St. Louis, Missouri (hereinafter called American Life), or any of its officers, which indicates American Life's receipt of, acceptance of, or adherence to the Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance, promulgated by the Federal Trade Commission on February 3, 1950.

(b) All correspondence between American Life or any of its officers or employees, on the one hand, and the Federal Trade Commission, any of its members, or any member of its staff, on the other, which refers to such card or writing.

2. (a) All correspondence between any member of the public, on the one hand, and the Federal Trade Commission, any of its members, or any member of its staff, on the other, which both (1) refers to either of American Life's insurance policies known variously as the Provider policies and as form 632 4-52 (identified as Commission's

Exhibit 42 in the above named proceeding) and 631 11-50; or to any piece of American Life's literature or any radio broadcast for American Life referring to either of the policies named above, and (2) discusses any of the following: (A) the renewal, nonrenewal, renewability, or nonrenewability of either of the insurance policies named

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above; (B) the indemnity for surgical expense provided by either of the insurance policies named above; (C) the qualification or limitation of the lump sum benefit provided by either of the insurance policies named above for loss of life due to travel accident in a common carrier; (D) exceptions or exclusions from or limitations upon the indemnification provided by either of the policies named above for loss caused by hospitalization or surgical expense.

(b) In order to conceal the identity of any member of the public party to such correspondence, you may bring, in lieu of the documents described in paragraph 2(a) above, a copy of each such document, which copy omits (the place of each omission being indicated) the name and address of, and other information identifying, the member of the public party to such correspondence.

(c) If it is impossible, by the means indicated in paragraph 2(b) above, to conceal the identity of the member of the public party to the correspondence, you may bring, in lieu of any of the documents described in paragraphs 2(a) and 2(b) above as to which such concealment is impossible, a written statement of the number of persons who have been parties to such correspondence, of the date on which each such person first entered into such correspondence, and of whether or not the correspondence shows that each such person ever was, or ever was solicited by American Life to become, a policyholder of American Life.

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3. (a) Every copy received at the Federal Trade Commission before February 3, 1954 of each of the insurance

policies of American Life known variously as the Provider policies and as forms 632 4-52 (identified as Commission's Exhibit 42 in the above named proceeding) and 631 11-50.

(b) Every copy received at the Federal Trade Commission before February 3, 1954 of each piece of American Life's literature and of each of American Life's radio scripts referring to either of the policies named above.

4. All writings, notations, and memoranda prepared by the Bureau of Consultation of the Federal Trade Commission, any predecessor organization of the Bureau of Consultation, any member of its staff, or any member of the staff of any of its predecessor organizations, between February 2, 1950, and October 19, 1954, which refer to any of the following: (1) any of the documents described in Paragraph 3 above; (2) any examination or review of any of such documents before October 19, 1954; (3) any conference between members of the staff of the Bureau of Consultation or any of its predecessor organizations, on the one hand, and A. Alvis Layne, Jr. or Wendell Berge, on the other.

Respondent's Exhibit 1

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[Caption Omitted]

APPLICATION FOR ISSUANCE OF SUBPOENAS

To Hearing Examiner J. Earl Cox:

Respondent respectfully applies, pursuant to Section 3.17 of the Commission's Rules of Practice and Procedure, for the issuance of the attached subpoena *duces tecum*, addressed to Robert M. Parrish. The grounds of relevancy and the general scope of the documents sought by the subpoena are the same as those of the documents sought by respondent in *Postal Life & Casualty Insurance Company*, Docket No. 6276; respondent assumes that the

Examiner will here follow his ruling in that case in respect to the subpoenas, but submits this application for purposes of the record herein. It is suggested that the Examiner follow the procedure there adopted of issuing the subpoenas and ruling upon them upon motion to quash, if such a motion is made. For purposes of the present record the general relevancy and reasonable scope of the subpoenas is shown below. With this application respondent

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is filing with the Commission, pursuant to Rule 1.135, as an alternative, a request for release of confidential documents, in anticipation of a claim that the documents sought by the subpoena are confidential. Respondent assumes that the Examiner will proceed to issue the subpoena pending disposition of the request. Respondent would have wished to apply for subpoenas *ad testificandum* directed to certain members of the Commission's staff for the purpose of obtaining their testimony as to the scope, operation, and effect of the Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance, Promulgated February 3, 1950, and as to the course of dealing between respondent and the Commission under these Rules. However, in view of the refusal of Commission personnel at the hearing in *Postal Life & Casualty Insurance Company, supra*, to testify as to such matters, respondent believes that no useful purpose would be served by issuing such subpoenas until after a determination of their right to refuse to testify. Accordingly, for the purpose of saving the time of the staff members in question, no application for such subpoenas is made at this time.

The documents sought are identified in a schedule of four paragraphs, attached to the subpoena.

1. Paragraph 1(a) asks for the production of a card, which the respondent will present testimony of its having signed, indicating receipt of or adherance to the Commission's Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance. The rele-

vancy of this document is in connection with evidence that respondent expects to present, indicating that it adhered to and complied, throughout all relevant times, with the

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Trade Practice Rules. This evidence relates to repondent's contention that these rules sanctioned, or failed to forbid, the practices complained of by the Commission as unlawful. Cf. *Wildroot Company, Inc.*, Docket No. 5928 (decided June 30, 1953). The scope of the demand is limited to a single document. Paragraph 1(b) calls for correspondence covering the transmittal of the signature card between the company and the Commission, which is relevant to the issue of the Commission's knowledge of respondent's adherence to the Trade Practice Rules. Not more than two or three documents should be involved.

2. Paragraph 2 contemplates the production of documents relating to the possible existence of complaints made by members of the public, either before or after the institution of this case, about respondent's literature or its policies, to the extent that these are now in issue in this case. In demanding documents dealing with complaints, respondent has included in the subpoena two alternative methods by which the Commission may comply with the subpoena without disclosing the identity of the persons complaining, thereby protecting any supposed privilege of the Commission. The complaints sought are those which discuss, with respect to respondent's Provider policy, or its predecessor, any of the provisions complained of in Paragraphs Six and Seven of the complaint as having been misrepresented. The demand is therefore restricted to complaints pertaining to the practices of which, as respondent understands the proceedings to date, the record contains evidence of possible deception. The relevancy of documents pertaining to public complaints lies in their relation to two contentions of respondent: (1) the contention that, this case being one of first impression, and the

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Commission having had little or no experience with public

complaints about the practices alleged to be unlawful, the Commission can lay no claim to administrative "expertise" in evaluating the practices; and (2) the contention that there is little or no public interest in the institution of this proceeding.

3. Paragraph 3 requests every copy of the Provider policy, and of its predecessor, and every copy of each advertisement referring to these policies received by the Commission before the date on which respondent became aware of the Commission's general investigation of insurance. The documents demanded are limited to those in evidence to date, together with predecessor policies and literature of similar content to those in evidence. The relevancy of these documents lies in their relation to respondent's contention that the documents now in evidence, as well as documents containing statements identical or similar to those complained of by the Commission, were submitted to personnel of the Commission *ante litem motam*, and that the Commission was repeatedly made aware of the existence and content of the documents and was repeatedly given an opportunity to complain of their content, with reference to the Trade Practice Rules or otherwise. This contention, respondent submits, goes to the ultimate issue of public interest. Cf. *Argus Cameras, Inc.*, Docket No. 6199 (decided October 29, 1954). It also goes to respondent's contention that the Commission personnel whose opinions were most expert in the field regarded respondent's practices, here in issue, not unlawful. Duplicates of all documents are sought, where duplicates exist, in order to show the quantitative extent of respondent's submittals.

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4. Paragraph 4 requests interoffice memoranda, and the like, made in the Bureau of Consultation, to the extent that such memoranda relate to the submittal of the policies and literature or to conferences about such documents between personnel of the Bureau of Consultation and counsel for the parties to the Trade Practice Rules. The purpose for which respondent seeks these memoranda is to show

that respondent's policies and literature, including provisions and statements now alleged to be unlawful, were discussed with, found unobjectionable by, and approved by Commission personnel, with reference to the Trade Practice Rules and otherwise. This purpose again goes to the ultimate issues of public interest and of the opinion, as to the merits, of the Commission's most expert personnel. By limiting the subpoena to documents of the Bureau of Consultation and its predecessors, respondent has sought to exclude work papers and memoranda made in view of the present litigation, thereby protecting any supposed privilege of the Commission.

Respondent requests that the Examiner sign the attached subpoena and return it to the Commission for processing and service.

Respectfully submitted,

s/ A. Alvis Layne, Jr.
A. Alvis Layne, Jr.

s/ T. S. L. Perlman
T. S. L. Perlman

Attorneys for Respondent
Pennsylvania Building
Washington 4, D. C.

Colloquy of Examiner and Counsel Disposing of Application and Requests for Issuance of Subpoenas and Motion to Quash Subpoena

[Tr. 445] Hearing Examiner Cox: In this case, there is an application for release of information filed by the Respondent. I am wondering if there has been any response to that?

Mr. Layne: No, there has not been. Not to my knowledge.

I might point out to the Examiner that a similar application has been filed in another proceeding, also an insurance proceeding and is on its way up to the Commission as well. I have not heard from either of them.

HEARING EXAMINER COX: Were they both filed at the same time?

MR. LAYNE: No, they were filed almost simultaneously, but I think they were a day apart. As a matter of fact, the application in this case was earlier than the one in the other case.

However, I have not heard as to any action that may have been taken with respect to them.

HEARING EXAMINER COX: Do you know, Mr. Mayer, whether there has been any action taken?

MR. MAYER: No, sir, I do not. I have not heard anything about it.

HEARING EXAMINER COX: There was also an application for the issuance of subpoena and the subpoena was issued. Has there been any Motion filed with respect to that?

MR. MAYER: Yes, sir, we did file a Motion to [Tr. 446] quash, I believe, with the Secretary last Thursday.

And, unfortunately, the copy of the Motion that I have in my possession this morning is one of the last carbons, as the Examiner can see; but it generally is the same type of Motion or same basis for the Motion as was made in the Postal Case.

HEARING EXAMINER COX: Have you received a copy of that?

MR. LAYNE: I just received one this morning. The attorneys supporting the complaint, gave me one after we reached the room this morning.

HEARING EXAMINER COX: Of course, the Secretary's office is a block away from the Hearing Examiner's office, and we would not expect too prompt service. Up to now, the record may show the Hearing Examiner has received no copy of the Motion to quash the subpoena duces tecum,

except the copy which was just handed him by Counsel in support of the complaint.

Off the record.

(Discussion off the record.)

HEARING EXAMINER COX: (On the record.)

Well, the ruling on the Motion to quash will be sustained in this case, as it was in the previous similar proceeding, which was Docket No. 6276, the title of the case being Postal Life and Casualty Company Case, that is, that [Tr. 447] the Motion will be sustained as to the specific items mentioned in paragraph numbered 1, 2 and 4, and overruled as to the items referred to in paragraph numbered 3 and the ruling will be for the same reasons stated in the Postal case.

I think that clears everything up to the introduction of evidence.

MR. LAYNE: I am not sure, Mr. Examiner, whether it is the practice of this Commission that a copy of the application for the issuance of the subpoena would appear anywhere on record.

HEARING EXAMINER COX: It would not.

MR. LAYNE: Would there be objection to including as a part of the record in this proceeding a copy of the application in order that we may save time?

In the Postal Case I orally reviewed the reasons for the asking of the subpoena. In this proceeding, we have a written application which sets out our reasons. May we include that as part of the record?

HEARING EXAMINER COX: Is there any objection to that?

MR. MAYER: I don't object.

HEARING EXAMINER COX: It may be included as a part of the record and may be marked, if you wish, as Respondent's Exhibit No. 1.

MR. LAYNE: I ask that there be marked Identifi- [Tr. 448] cation as Respondent's Exhibit No. 1, a document of five pages, each of which is numbered, entitled "Application

for issuance of Subpoena", addressed to Hearing Examiner J. Earl Cox. May that be so marked, Mr. Examiner?

HEARING EXAMINER COX: It may be so marked, and there being no objection, it may be received in evidence.

(The document referred to was marked Respondent's Exhibit No. 1 for identification and received in evidence.)

MR. LAYNE: Mr. Examiner, in the Postal proceedings, during the course of the discussion on the subpoena duces tecum, in that proceeding, it developed that, at least as I understood the ruling in that case, that you quashed the subpoena duces tecum, insofar as it applies to paragraph one which relates to the signatory card that was signed by Respondent on the ground that there was no controversy and that that was to be taken as a fact. I wonder if that is true in this proceeding?

HEARING EXAMINER COX: Well, had the Respondent filed a signatory card in this case?

MR. LAYNE: Yes, sir, we filed such a card.

HEARING EXAMINER COX: Mr. Mayer, you do not deny that that is a fact, do you?

MR. MAYER: No, sir.

HEARING EXAMINER COX: Well, that may be in this record also, that the Respondent in this case has signed a card [Tr. 449] indicating their adherence to the Trade Practice Rules, and that the Commission and the Hearing Examiner will take notice of that fact.

MR. LAYNE: Also, in that proceeding in connection with the subpoena and those paragraphs which are addressed to the production of complaints, it was noted that a failure or an absence of such complaints in the record would be taken by Respondent in the Postal Life and Casualty Case, Docket 6276, as an indication that there were no such complaints. Is that proper in this proceeding as well?

HEARING EXAMINER COX: That is one of the items that you have requested the Commission to authorize the staff to furnish, is it not?

MR. LAYNE: Yes, it is, sir.

HEARING EXAMINER COX: I think that would be a proper ruling if that request is denied. I hesitate to make it in absence of a decision by the Commission.

MR. [illegible]: I understand, sir.

There was one further preliminary matter. As I think the discussion thus far, this morning, has indicated to a considerable extent, the Respondent in this proceeding is faced with somewhat similar questions as faced by the Respondent in Postal Life and Casualty, Docket 6276. I would like to note on the record, at this time, if it is not improper, that the Respondent in this proceeding, did not issue subpoenas [Tr. 450] ad testificandum to employees of the Commission in the belief that somewhat similar rulings would be made with respect to the matters which might be attempted to be elicited by testimony and, I did that in an effort to save the time of this hearing and in an effort to save the time of the personnel of the Commission.

I wonder if we can in any way establish, without extended effort, that if attorneys or members of the Bureau of Consultation or formerly the Bureau of Cooperation, formerly the Bureau of Trade Practice Conferences were called and they were asked as to reports that may have been made by them or reports they may have read concerning compliance by this Respondent with the Trade Practice rules of the Federal Trade Commission, relating to the advertising and sales promotion of mail order insurance, promulgated on February 3, 1950, that there would be objection on the grounds that that confidential information could not be elicited without the Commission's permission.

I merely want, Mr Examiner, to protect the Respondent's record at this juncture in view of the fact that we have pending before the Commission an application for release of such information, such testimony. However, in order that the record might be clear, I think I should note that I do not believe—The position of counsel for the Respond-

ent is that he is entitled to that evidence, that [Tr. 451] testimony to those records, irrespective of the ruling of the Commission, upon such an application, under the applicable statutes which set out the rights of the Respondent, before this and other agents.

HEARING EXAMINER COX: Do you have any comment as to that, Mr. Mayer?

MR. MAYER: Well, if Mr. Layne can call any witnesses he pleases, or apply for any subpoenas that he pleases, it seems to me the question of whether or not the witness did not answer properly or within the scope of his knowledge, or within the scope of his official duties, can hardly be tested other than on the direct questioning. However, I am frank to admit I would object most strenuously if the attempt by oral testimony was to produce what is confidential in the official records of the Commission.

HEARING EXAMINER COX: Would you read that last statement, the last sentence?

(The reporter read back this statement.)

HEARING EXAMINER COX: The reason I asked that to be read, Mr. Mayer, is that I am wondering what you include in that term "confidential"? There is some argument as to whether or not all these matters that were objected to are confidentially, actually, or in the opinion of the staff, or in the opinion of the Commission. When you use the term "confidential", can you explain any more clearly how you use [Tr. 452] that term?

MR. MAYER: Frankly, I think the question as to what is confidential and what is not confidential at this moment, is solely an opinion of the Hearing Examiner.

HEARING EXAMINER COX: The hearing Examiner——

MR. MAYER: Since a memorandum, for instance, is confidential because it is part of the books and records of the Commission of an attorney forwarding a case, or doing anything with a case, not particularly limited to the trade practice conference procedure, I think that he would be unable to testify according to the content of that memorandum without a release by the Commission itself. I

think that came up almost identically in the Sylvania matter at one time, when the information attempted to be elicited was in the form of a memorandum written by a member of the staff.

HEARING EXAMINER COX: Let's go back to this for the record. I take it, Mr. Mayer, you have read the record transcript in the Postal Case?

MR. MAYER: No, sir, I have not.

HEARING EXAMINER COX: It is going to take some time if we have to bring these witnesses in and ask them specific questions, and get specific rulings on the questions. It would expedite these hearings, if we could understand that the same objections would be made, the same rulings followed, as occurred in the Postal Case.

[Tr. 453] I am wondering, Mr. Layne, if you can state for the record those things that were objected to in the Postal Case that would occur in this case, and get Mr. Mayer's reaction to those. It would be quicker, I think, than getting the witnesses in.

MR. LAYNE: I will attempt to do so, yes, sir.

In the Postal proceeding and in order to save time, the type of information to be elicited would be from members, employees of the Bureau of Consultation or formerly the Bureau of Cooperation, formerly the Bureau of Trade Practice Conferences, as to reports that may have been made concerning compliance by this Respondent with the trade practice rules of the Federal Trade Commission promulgated on February 3, 1950; reports as to reviewing by attorneys of the Bureau with respect to the advertising materials and policy forms which have been identified previously in this proceeding as documents upon which the Commission now relies.

HEARING EXAMINER COX: Reports made by whom and to whom, Mr. Layne?

MR. LAYNE: They would be reports made by the attorney or the supervisors of the attorneys in charge of rule administration to the Directors of the Bureau or by the Directors of the Bureau to the Commission itself concern-

ing the compliance and the review made of the advertising material that had been submitted by Respondent between February 3, 1950, [Tr. 454] and the date upon which the complaint in this case was issued. That would exclude, however, and will be intended on my part to exclude any reference to the documents or reports which may have been made by the Bureau of Investigation of this Commission or by the Bureau of Litigation of this Commission, in connection with any anticipated or possible complaint proceeding for cease and desist under Section 5.

HEARING EXAMINER COX: I understand, Mr. Mayer, objection will be made to all those.

MR. MAYER: Yes, sir, and I might suggest that frankly in Mr. Layne's statement, I do not see anything that is not contained in his request here in his subpoena, for application of subpoena, and since that is a matter of record I at least believe he will appeal from the quash.

HEARING EXAMINER COX: Well I am going to——

MR. MAYER: It will get to the Commission on that basis.

HEARING EXAMINER COX: I am going to state for the record that I understand the same objections would be made in this case as were made in the Postal case and that the same rulings will be made.

MR. LAYNE: Thank you, sir.

* * * * * * * * * * * *

[Tr. 536] * * * I would like to ask Counsel if there is to be any appeal in this case from the ruling on the motion to quash the subpoena duces tecum or is there agreement that Counsel [Tr. 537] will be bound by the appeals filed in the other proceeding? I refer to the Postal case.

MR. MAYER: That is satisfactory with me.

MR. LAYNE: It is satisfactory with me. There is no use going through this twice.

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[Caption omitted]

Order Denying Application for Disclosure of Information

This matter having been heard by the Commission upon the application of counsel for American Life and Accident Insurance Company, respondent in the above-captioned proceeding, for the disclosure of certain documents or information in the Commission files; the applicants stating that the documents or information requested, if obtained, will be used as evidence in opposition to the Commission's complaint charging American Life and Accident Insurance Company with the use of unfair and deceptive acts and practices in connection with the advertising and sale of insurance coverage; and

The Commission having duly considered said application and having concluded that, aside from the fact that certain of the documents requested are confidential material to which the applicants have shown no legal right and the disclosure of which would be contrary to the public interest, the documents or information requested are in no way relevant or material to any issue in the proceeding and that, therefore, the applicants have shown no real or actual need for the disclosures sought; the reasons for such conclusion being substantially the same as those for which the Commission, in its per curiam opinion rendered

(289)

on January 10, 1956, denied the application of the respondent in the matter of Postal Life and Casualty Insurance Company, Docket 6254, for disclosures similar to those sought by this application;

IT IS ORDERED that the application of counsel for American Life and Accident Insurance Company for the release of information be, and it hereby is, denied.

By the Commission.

s/ ROBERT M. PARRISH
Robert M. Parrish,
Secretary.

(SEAL)
ISSUED: January 11, 1956

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION
COMMISSIONERS:

JOHN W. GWYNNE, *Chairman*
LOWELL B. MASON
ROBERT T. SECREST
SIGURD ANDERSON
WILLIAM C. KERN

In the Matter of
POSTAL LIFE AND CASUALTY INSURANCE COMPANY,
a corporation

DOCKET NO. 6276

Opinion of the Commission

Per Curiam:

This matter is before the Commission on cross-appeals from certain actions of the hearing examiner.

The complaint charges respondent with having used misleading and deceptive representations in connection with the advertising and sale of certain of its accident and health insurance policies. During the course of the hearings on the complaint, the hearing examiner, upon application of the respondent, issued a subpoena duces tecum directing the Secretary of the Commission to produce certain documents or information from the Commission's files. A motion by counsel supporting the complaint to quash the subpoena was granted in part and denied in part by the hearing examiner. Respondent has appealed from the hearing examiner's action of quashing that portion of the subpoena which demanded the production of certain memoranda or other writings prepared by members of the Commission's staff. In the alternative, respondent, in its appeal, has requested that the Commission order the release of the documents sought. Counsel supporting the complaint, on the other hand, has appealed from the hearing

examiner's failure to quash the subpoena in its entirety. Counsel supporting the complaint has also appealed from the hearing examiner's action of permitting respondent to introduce testimony as to the past course of dealing between the respondent and the Commission and has requested the Commission to order certain testimony stricken from the record.

We consider first the subpoena duces tecum issued by the hearing examiner.

Pursuant to statutory authority, the Commission, like most other agencies and departments of the Federal Government, has prescribed rules and regulations covering the custody, use and protection of material and information coming into its possession, or within the knowledge of the Commission or any of its officers or employees in the discharge of their official duties. Respondent, in its appeal, does not question the legality of these rules and regulations. Under the prescribed rules, the release of confidential information or material from the Commission's files may be authorized only by the Commission itself. The procedure to be followed by a party desiring the disclosure of information or material from the Commission files is clearly set forth in § 1.134 of the Rules. No other method for obtaining the release of confidential information is provided for in the rules. It follows that the hearing examiner has no authority to require the production of information or material from the Commission's files by a subpoena duces tecum or otherwise. The hearing examiner, therefore, erred in issuing the subpoena and also in failing to grant in its entirety the motion of counsel supporting the complaint to quash the subpoena. Accordingly, insofar as the appeals relate to the subpoena duces tecum issued by the hearing examiner directing the Secretary of the Commission to produce certain documents or information, the appeal of the respondent is denied and the appeal of counsel supporting the complaint is granted, and the subpoena will be quashed.

We consider next respondent's alternative request, under § 1.134 of the Commission's Rules of Practice, that the Commission order the release and production of the documents sought. As indicated by the rule, the Commission in determining the action to take upon an application for the release of confidential information will consider not only whether or not the information or material sought is confidential or privileged so far as the applicant is concerned, but also the purpose for which the applicant intends to use the information or material. Here, the applicant states that the documents requested will be used as evidence in opposition to the Commission's complaint. It, therefore, is necessary to consider whether or not the data requested would in any way be helpful to the respondent in establishing a valid defense to the proceeding. This, in turn, requires a consideration of the asserted defense to which the applicant claims the information and material is relevant. This is especially required in connection with the application since some of the documents requested are already in evidence and, therefore, available to the applicant, and the applicant has made no showing that it does not have copies or originals of certain of the other documents requested.

As a defense to the proceeding, respondent alleges that it accepted and adhered to the Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance promulgated by the Commission, that it submitted its insurance policies and literature to the staff of the Commission's Bureau of Consultation and that the Bureau approved, or failed to disapprove, the practices challenged by the complaint. In support of this defense, respondent cites the Commission's action in dismissing the complaints in *Argus Cameras, Inc.*, D. 6199, and *Wildroot Company, Inc.*, D. 5928. In both of those proceedings, the complaints were dismissed after a showing by the respondents that the particular practices challenged by the complaints had been abandoned and that there was no likelihood of the practices being resumed. Evidence as to

the respondent's past course of dealings with the Commission was considered in connection with the determination as to whether or not there was likelihood that the practices might be resumed.

In the instant case, respondent makes no claim that it has discontinued any of the practices challenged by the complaint. The question here is whether or not the respondent has engaged in unfair and deceptive acts and practices as alleged in the complaint. Respondent's prior course of dealing with the Commission, or with members of its staff, has no bearing on whether the respondent has engaged in the alleged unlawful practices. If it were established that the Commission, or a member of its staff, had at some time in the past conveyed to the respondent the impression that the practices involved were not objectionable, that fact would constitute no valid defense to this proceeding. (*Book-of-the-Month Club* v. *F.T.C.*, 202 F. 2d 486, 1953; *In the Matter of Carpel Frosted Foods, Inc.*, et al., 48 F.T.C. 581, 1951.) Aside from the fact that certain of the documents requested, namely, memoranda prepared by members of the Commission's staff, are confidential material to which the respondent has shown no legal right and the disclosure of which would be contrary to the public interest, we do not believe that the applicant has shown any real or actual need for the disclosures requested. Respondent's application for the release of information, therefore, is denied.

This leaves for consideration that portion of the appeal by counsel supporting the complaint relating to the hearing examiner's rulings permitting the introduction of testimony as to the past course of dealing between the respondent and the Commission and the hearing examiner's refusal to rule on the motion of counsel supporting the complaint that the testimony of Alvis Layne, Jr., Henry Miller, and Donald K. King be stricken. The reception of evidence is the function of the hearing examiner, Administrative Procedure Act, Section 7(b), 60 Stat. 241, 5 U.S.C. 1006(b), Commission Rules of Practice, § 3.15 (c), and it is for him,

during the course of trial, to admit or exclude testimony and other evidence. The correctness of his rulings in that regard can best be determined at the conclusion of the hearing when the matter comes before the Commission for final decision on the merits. We therefore deny this portion of the appeal by counsel supporting the complaint.

In the view we take on the appeals and the application, oral argument thereon, which was requested by respondent, is not necessary and would serve no useful purpose.

An appropriate order will be entered.

January 10, 1956.

S. Brad Hunt,

on behalf of respondent, testified as follows (November 21, 1955):

[Tr. 459] * * * MR. LAYNE: Mr. Hunt, let me ask you this. Are there occasions when, after a policy has been issued, has been in force and the anniversary date or a premium due date appears and the policy holder has tendered a premium, and the company is aware that the risk is impaired, that it continues that and accepts that premium.

A. Yes, sir.

Q. Now, what is the policy of the company with respect to continuation of such policy?

MR. MAYER: Objection, unless it is confined to instances in which the risk has become impaired to the knowledge of the witness. It was the basic question.

HEARING EXAMINER COX: Well, I did not draw the complaint and there is a statement in it, and I have no notion why it is there. I do not know what it means and [Tr. 460] since it is there, I am going to let the witness answer.

MR. LAYNE: Would you read the question, please?

(The reporter read the question back.)

THE WITNESS: We do not refuse to renew a policy, even though the insured is impaired—health is impaired, unless

the insured has collected more benefits than they have paid premiums.

* * * * * * * * * *

[Tr. 476] * * * Q. Now, can you tell us Mr. Hunt, why you ordered that substitution to be made?

A. May I use the name of the Commissioner, one of the members of the Commission?

Q. Use any names you want to if you can tell us the reason why.

A. At our annual meeting at Omaha in May——

Q. Annual meeting of what?

A. Of the Association for the Advertising Association:

Q. Referring to the Association of Insurance Advertisers?

A. Yes, sir.

MR. MAYER: Mr. Examiner, before he completes [Tr. 477] the answer, if I may interrupt, I do not think this is related to any trade practice conference procedure, is it, and I think——

HEARING EXAMINER COX: I do not know.

MR. MAYER: He has not shown any relation to it and I think this is immaterial on any scope.

MR. LAYNE: Am I limited in my examination of this?

HEARING EXAMINER COX: Let's hear the answer.

THE WITNESS: Mr. Sills was our guest speaker and in our conference and during our meeting, that was one of the things that I found out that was objectionable by Mr. Sills was the fact that we did not disclose that the policy was renewable at the option of the company, something that I thought every company practically was guilty of at that time, and I brought it up in the form of a Motion before the Association that we should do something about it. And, as soon as I returned to St. Louis I proceeded to do this, and discontinue what we had been doing previously.

By Mr. Layne:

Q. Had any member of the Trade Practice Rules Administration Division said anything about renewal or nonrenewal of policies to you prior to that time?

A. No sir.

Q. Did Mr. Sills in his talk—and whatever you may have [Tr. 478] heard was he addressing himself to you, particularly, your company in particular?

A. No, sir, to the Association.

A. Alvis Layne, Jr.,

on behalf of respondent, testified as follows (November 21, 1955):

Direct Examination

My residence is Washington, D. C. I am a lawyer and I am attorney for respondent in this case. I went to George Washington University and I graduated from George Washington University Law School in 1945. For a little more than a year I was Law Clerk to the Chief Judge of the United States Court of Appeals for the District of Columbia. In 1946 I was associated with a law firm in the District of Columbia; later I was a partner of that firm. Mr. Wendell Berge was also a partner of the firm until dissolution of the firm in July 1953. In July 1953 I became a partner in the firm of Layne and Ephraim, offices in Washington, D. C. I first became associated with the American Life and Accident Insurance Company in 1948 when that company, with others, sought to establish rules to govern advertising practices in the insurance industry.

I represented American Life and Accident then and I have since 1948. It has been a member, with others, of an Association, the purpose of the Association being to obtain from appropriate authority, state and federal, and to observe, rules governing advertising practices.

In 1948 on behalf of American Life and Accident Insurance Company and other insurance companies, I applied—I and Mr. Berge—to the Federal Trade Commission for a trade practice conference to specify rules relating to advertising practices in the insurance industry.

Respondent's Exhibit 3 is a true copy of the letter which was sent to the Federal Trade Commission by Mr. Berge and which I drafted for his signature requesting the Federal Trade Commission to hold a trade practice conference for that purpose.

The Commission responded to that letter by Respondent's Exhibit 4 and said, the letter I think speaks for itself, responded to that application.

The American Life and Accident, as well as other companies, were very interested in obtaining from the Commission at that time rules governing advertising, and in particular, the application of Section 5 of the Federal Trade Commission Act that might apply to advertising of insurance policies. At that time American Life and Accident, and I had discussed with its President, was aware of the provisions of the McCarran Act, so-called Public Law 15, and it was shortly after June 30, 1948—shortly before that date—that the application was made.

The Federal Trade Commission thereafter, in November 1948, announced to the industry and to American Life and Accident, that a trade practice conference would be held, relating to the advertising and sales promotion of so-called mail order insurance. I had, on behalf of American Life and Accident and other insurance companies, a number of conferences with members of the staff of the Bureau of Trade Practice Conferences prior to November 1948 discussing the scope of the industry to be covered by the rules and discussing also what proposed rules, if any, would be submitted to the trade practice conference for the consideration of the industry and of the Commission.

During these conferences with the staff I had pointed out and given to them copies of the rules which the Asso-

ciation had itself adopted in June 1948. These Association rules were adopted with the help and advice of the Post Office Department and the Solicitor's office, the Solicitor and the Assistant Solicitor of the Post Office Department being particularly helpful, and the inspector in charge of insurance cases was also helpful in giving advice as to the rules.

It was at the suggestion of the staff of the Bureau of Trade Practice Conferences that the Association—or that I, on behalf of American Life and Accident and other companies, and Mr. Berge—presented to the Trade Practice Conference basically those rules that had previously been adopted with such changes as to form and format, and with some additional suggestions that were made, that would conform to the format and makeup of trade practice rules that were usually promulgated by the Commission in various industries.

Respondent's exhibit 5 is a letter of November 15, 1948 signed by Henry Miller, who was then Director of the Trade Practice Conference Bureau of the Commission, announcing the Trade Practice Conference in which American Life and Accident subsequently participated.

At this point Respondent's Exhibits 3, 4 and 5 were received in evidence.

The Association of Insurance Advertisers submitted on behalf of its members, including the respondent, suggested trade practice rules. At the meeting which was called by Mr. Miller's letter, by the Commission, to be held in December in Chicago, Mr. Berge and I presented on behalf of American Life and Accident and other insurance companies, a draft of rules which had been discussed, which had been worked out as a draft with the staff of the Commission, the staff members being Mr. Paul Cameron, Mr. David Stauffer, and Mr. Henry Miller.

Respondent's Exhibit 6 is the draft as it was presented to the Trade Practice Conference in Chicago. That draft was discussed provision by provision by the persons pres-

ent, including representatives of various insurance companies, a number of insurance companies, trade associations of insurance organizations, and state insurance commissioners who were in attendance at the meeting.

I was in attendance at the Trade Practice Conference at which this draft was submitted, with a representative of the Commission, namely Mr. Henry Miller. The conference itself was presided over by then Commissioner Davis of this Commission. Also in attendance were Mr. Paul Cameron, Mr. David Stauffer, and a representative of the the Assistant General Counsel's office of the Commission. The Commission took all the suggestions that were made and Respondent's Exhibit 6 was the only written suggestion made to the Conference. There were some made orally by others. They took all that under advisement, all that was said and all that was submitted.

Subsequently as they had announced they would do, there was circulated by the Commission proposed trade practice rules for the mail order insurance industry together with a notice of a hearing on those proposals made by the Commission itself. Respondent's Exhibit 7 is a copy of the announcement of the hearing and of the proposals made by the Commission. The hearing was to be held in May 1949.

The proposals of the Commission themselves proposed to limit the rules to advertisements which were circulated by an insurance company by interstate media, but without the intervention or use in connection with the advertisement or the solicitation of any licensed agent of the insurance company, and thus were limited as they said in the title to trade practice rules for the so-called mail order insurance industry.

At the time that these proposals were under consideration, Mr. Berge and I again had a number of conferences with the staff of the Commission that were handling the matter and which had been assigned to this Trade Practice Conference. I have previously given their names. We

supplied them with information, in at least one instance with policies and advertising materials for examples for their study, and in whatever other way we could assisted the Commission staff in prep ring these rules on behalf of the respondent in this case and other insurance companies.

Respondent's Exhibits 6 and 7 were here received in evidence.

I was present at the conference at which were discussed the proposed rules. The outcome wasn't apparent, at least right at that moment. The conference was held in the Federal Trade Commission Building here in Washington, D. C. There were extended discussion by Mr. Berge and myself in behalf of American Life and Accident and other insurance companies and by other representatives of other companies and associations and by state insurance commissioners of the proposals that had been made in Exhibit 7. At the conclusion of that day of conference, the Commission staff announced—Mr. Miller announced—that all suggestions would be taken under advisement and that in due course the Commission would publish something further in connection with the conference.

The final outcome of that was that the Commission promulgated trade practice rules for the advertising and mail order promotion of mail order insurance and it was promulgated by the Commission as rules on February 3, 1950.

The hearing examiner here ruled that official notice would be taken of the rules.

The rules were brought to the attention of respondent. On February 3, 1950 the Commission announced the rules to the public, published them, and sent them to all insurance companies, together with a signatory card, and requested that all companes intending to adhere to the rules sign the card and return it.

I was contacted by American Life and Accident Insurance Company with respect to whether they should return the card. I advised—Mr. Berge and I advised—American

Life and Accident as we did all companies that we represented to sign the card and return it to the Commission.

Thereafter I participated in the administration of the rules. I was informed by the staff of the Bureau—I am not sure whether the name had then been changed from the Bureau of Trade Practice Conference to the Bureau of Cooperation; at some point about that time the name was changed—that the rules were sent or turned over to the Rule Administration Division of the Bureau and that a Mr. James W. Millspaugh, attorney of that Bureau, had been assigned to the administration of those rules. I was so advised not only by those with whom I had previously been dealing but also by Mr. Millspaugh, who contacted me.

Beginning in 1950 on behalf of the American Life and Accident Insurance Company, I had repeated and constant dealings with Mr. Millspaugh between that time, February 3 or shortly thereafter, 1950 up until shortly after the announcement by this Commission of the general investigation of accident and health insurance companies.

My dealings with Mr. Millspaugh on behalf of American Life and Accident were by letter; they were by personal visit and discussion in conference in his office; and they were by telephone. There would be a large number of such conferences and such telephone calls during the period.

I would discuss with Mr. Millspaugh—and did discuss with Mr. Millspaugh—the advertising of American Life and Accident Insurance Company repeatedly and also any matters that came up or came to the attention of the Trade Practice Conference people during that period.

My relation with Mr. Millspaugh and the administration of these rules and in obtaining compliance with the trade practice rules continued until Mr. Millspaugh informed me that, due to the general investigation instituted by the Commission, he was not sure—and I could find no one else in the Commission who was sure—who if anyone was administering the trade practice rules.

After the rules, in early 1951, Mr. Millspaugh called me on the telephone and said he had a great deal of adver-

tising material to review in connection with the trade practice rules—a substantial number of companies. He said that he was aware that under the rules of the Association in which American Life and Accident was a member, American Life and Accident had filed with me and with Mr. Berge copies of their policies and their advertising material. He requested that a Mr. Harold Kennedy who had been assigned to help him in the initial review of these materials be permitted to review the advertising materials of American Life and Accident and other companies which Mr. Berge and I represented, in our office. And I told him that we would be happy to have Mr. Kennedy come to the office and review the material.

Mr. Kennedy reviewed the material of American Life and Accident Insurance Company which was on file in my office at that time in the first part of February 1951. Mr. Kennedy was, or I was told that he was, by Mr. Millspaugh, an attorney for the Bureau of Trade Practice Conference, the Bureau of Consultation, assisting in the administration of these rules. Respondent's Exhibits 8B through 8S are the materials that were reviewed by Mr. Kennedy at that time. I would like to point out that they are almost identical to the material which has been identified in this record as the Commission's exhibits in the presentation of the Commission's case in chief.

As a result of that review Mr. Kennedy came to me. After he was finished he was assigned an office and given the materials. He came to me at the conclusion of reviewing all the materials—health and accident and life insurance material used by American Life and Accident Insurance Company—and told me that Respondent's Exhibits 8B through 8S, inclusive, were in compliance with the trade practice rules and that he had no suggestions to make.

He did, however, have a suggestion to make with respect to an advertisement used in connection with a life insurance policy. After he told me that I wrote immediately

to American Life and Accident Insurance Company under date of February 15, 1951 and told him the results of my conference with Mr. Kennedy. I sent a copy of that letter to Mr. James Millspaugh.

Respondent's Exhibit 8A is a copy of the letter that I wrote on February 15, 1951 to American Life and Accident Insurance Company. On February 20, 1951 I received a reply from Mr. Fred E. McGinity, Vice President of American Life and Accident Insurance Company, relating to the information I had given him concerning Mr. Kennedy's review and Mr. Kennedy's comments to me.

I never received any written reply to the copy I had sent to Mr. Millspaugh. I subsequently discussed with Mr. Millspaugh the fact that Mr. Kennedy had reviewed the material in the office and had found it unobjectionable and had no comments to make. I would like to say also that I wrote Mr. McGinity on February 23, 1951 in response to his letter to me regarding Mr. Kennedy's suggestions and that letter which I wrote is Respondent's Exhibit 9.

Respondent's Exhibits 8A through 8B, 9, 10A and 10B were here received in evidence.

Following my dealings with Mr. Kennedy I had other comment from Mr. Millspaugh about the advertising of the corporation. That was that on January 4, 1952 on one of my visits to Mr. Millspaugh's office—I do not now recall whether he had asked me to come down or whether it was when I stopped in to see him and asked him whether they had any comments concerning the members of the Association or any complaints, which I did on a regular basis—Mr. Millspaugh and I conferred. He asked me—he apparently had some correspondence from a member of the public or from some Senator, respecting a claim of a policyholder or someone who said they were a policyholder of American Life and Accident.

During that conference Mr. Millspaugh pointed out to me that advertising material of American Life and Accident Insurance Company had been reviewed by Mr. Ken-

nedy at the office of Mr. Berge and myself. He asked me if I would obtain for the Commission, for his files, for those of the Commission, a copy of all the advertising material then being used by American Life and Accident Insurance Company. I told him that I would and I wrote to the company the day following my conference with Mr. Millspaugh a letter, Respondent's Exhibit 11.

I wrote to Mr. Hunt [President of petitioner], told him about my conference, and asked him to forward an extra copy of all the material being used by American Life and Accident Insurance Company. A copy of my letter is Respondent's Exhibit 11.

Pursuant to that letter, as a result of that letter, I received from Mr. Hunt copies of old material. The material which I received from Mr. Hunt and which I supplied to Mr. Millspaugh was identical, so far as the hospitalization policies of American Life and Accident, to those which had been reviewed by Mr. Kennedy and which I have referred to as Exhibits 8B through 8S inclusive.

I then transmitted those copies to Mr. Millspaugh by letter dated January 15, 1952, asking Mr. Millspaugh for any comments he may have with reference to these materials. A copy of my letter is Respondent's Exhibit 12.

Subsequently, or two days later, I wrote Mr. Millspaugh again, on January 17, 1952, and sent him a copy of an additional rider which had come to my attention and which was applicable to the insurance policies, or some of them, issued by American Life and Accident Insurance Company. A copy of my letter to Mr. Millspaugh of January 17 transmitting this rider is Respondent's Exhibit 13.

Here Respondent's Exhibits 11, 12 and 13 were received in evidence.

Thereafter in the middle of March Mr. Millspaugh had concluded his review of the advertising materials which had been submitted to him and asked me to come to his office to go over the materials with him because he had some comments to make. I went to his office, as was my

practice in discussing these matters, and we took out the advertising material and the policy form and we discussed them in detail. As a result of that discussion Mr. Millspaugh said that it appeared to him that the advertising materials which I have previously referred to as Exhibits 8B through 8S were in compliance with the rules of the Commission and that he had only one suggestion which he would like to make. That was the suggestion that under this policy he believed that the advertising brochure, Respondent's Exhibit 8G, should contain a reference to the fact that benefits in payment for tuberculosis while in a hospital were limited to 60 days.

Other than that, if that was included in the letters and in the brochure, the letters being Exhibits 8H, 8I, 8J, 8K, 8M, 8N and 8O, with the inclusion of a statement to the effect that the benefits for tuberculosis were limited to 60 days, we believed that the material would be in compliance with the trade practice rules and would be satisfactory.

I thereupon, after discussion with Mr. Millspaugh of this matter and all the material, wrote to Mr. Hunt upon my return to the office, and told him of my conference with Mr. Millspaugh and of the suggestion that had been made. A copy of my letter to Mr. Hunt is Respondent's Exhibit 14.

Here respondent's Exhibit 14 was received in evidence.

The company responded to the letter. I received a letter from Mr. Rasada relating to the question of numbering, which Mr. Millspaugh had raised, of the form letters, which information I transmitted to Mr. Millspaugh by personal conference. Mr. Rasada's letter to me is Respondent's Exhibit 15. I also received a letter from Mr. Hunt, dated April 1, 1952, which speaks for itself. After that letter from Mr. Hunt I conveyed to Mr. Millspaugh and conferred with him again concerning the decision of the company which Mr. Hunt had recently made at that time, to provide a hospitalization policy so as to provide a time limit on all the benefits.

In only that respect, basically, was the policy changed. Theretofore Respondent's Exhibit 8B, which had been re-

viewed by Mr. Millspaugh, and which is the policy form, provided no time limit on hospitalization benefits for most sicknesses or most accidents if you were hospitalized. It had been the decision of the company, which I conveyed to Mr. Millspaugh, to limit the time over which benefits would be made for any sickness or any accident.

As a consequence of that change in the policy, of course, required some change in the advertising material, and that change would take account of the suggestion that Mr. Millspaugh had made with respect to advertising his 60 day limitation.

The letter which I received from Mr. Hunt, which announced his decision to me, is Respondent's Exhibit 16. Respondent's Exhibits 15 and 16 were shown to Mr. Millspaugh.

Here Respondent's Exhibits 15 and 16 were received in evidence.

I wrote Mr. Hunt on April 8 concerning the conference which I had had with Mr. Millspaugh, and told him of the results and asked him some questions, which information Mr. Millspaugh had wanted. Thereafter Mr. Hunt supplied me and I supplied to Mr. Millspaugh, pursuant to this discussion or conference which we had had, concerning this material, material which has been identified in this proceeding as Commission's Exhibits 1, 2, 3, 4, 5, 8, 9, 10, 11, 12, 13, 15, 16, 17, 18, 20, 21, 22, 24, 25, 26, 29, 30, 32, 36, and the various stuffers which have been received in evidence.

At the time this material was forwarded to me as it was prepared, including the policy form, Commission's Exhibit 42, I turned them over to Mr. Millspaugh as soon as I had ascertained that the material which was in almost every respect identical to that which had previously been reviewed by Mr. Millspaugh, included a statement of the time limitation on the benefits. As I turned them over by hand to Mr. Millspaugh I would ask him if he had any comments, criticisms, or objections under the trade practice rules concerning these materials. He told me he had none. I turned

them over as they were received by me at the office, and I also turned over to Mr. Millspaugh radio transcripts, Commission's Exhibits 1 and 2. Now I asked Mr. Millspaugh particularly in view of our prior conferences as to the advertising material if these were satisfactory under the trade practice rules or if he had any further criticism or suggestions relating to it. He said that he had none. I never received from Mr. Millspaugh, other than what I have detailed, any criticism or objection to the advertising material relating to hospital policies of American Life and Accident Insurance Company that I can recall.

I finished turning those materials over in July of 1952. I continued to see Mr. Millspaugh regularly after that up until sometime after the Commission instituted its general investigation of insurance, of accident and health insurance, in 1953.

In 1952 on behalf of American Life and Accident Insurance Company, I prepared and filed with the Commission a request for modification and further consideration of the trade practice rules relating to advertising and sales promotion of mail order insurance. Respondent's Exhibit No. 26 is a copy of a letter which I wrote to Commissioner Mead who was then the Chairman of the Commission, on this subject. On November 27, 1953 I received a copy of a letter from Allen C. Phelps who was the Assistant Director and Chief of the Trade Practice Conference Division of the Bureau of Cooperation, in response to that. Mr. Phelps' letter is Respondent's Exhibit 27.

Here Respondent's Exhibits 26 and 27 were received in evidence.

Thereafter I wrote to the Federal Trade Commission. The circumstances were that the Commission had instituted its general investigation of accident and health insurance companies and I was concerned and Mr. Berge was concerned that the Commission be aware of the trade practice rules which it had issued and of the cooperation which the American Life and Accident Insurance Company and other

companies had given to the Commission in connection with advertising—close cooperation which they had had with the Commission staff for a period of years. So Mr. Berge and I wrote to each member of the Commission identical letters, to each person who was then a Commissioner, February 19, 1954, in an attempt to point out to them the close cooperation which American Life and others had given to the Commission and assured the Commission of continued cooperation and asked the Commission for an opportunity to make any further revisions or to take care of anything that the Commission might desire in connection with advertising of the insurance policies of American Life and others. A copy of the letter is Respondent's Exhibit 28. On March 3, 1954 a reply was received from the Secretary of the Commission, Mr. Alex Ackerman, Jr., on behalf of, by direction of the Commission. A copy of that reply is Respondent's Exhibit 29. There was a further reply by me. On March 10, 1954 Mr. Berge and I wrote to Mr. Ackerman in response to his letter. Our letter is Respondent's Exhibit 30. As to whether I consider Respondent's Exhibit 29 an answer to the five identical letters that I wrote to the Commissioners, I will tell you frankly I didn't know what to think of it. I sure didn't get any other answer other than that from any individual Commissioner.

Here Respondent's Exhibits 28, 29, and 30 were received in evidence.

After the Commission announcement of its general investigation of accident and health insurance, I had further dealings with Mr. Millspaugh and others for the purpose of continuing the administration of the trade practice rules, to this extent: I went to Mr. Millspaugh and asked him if he had any pending and open matters or any questions concerning any of the members of the Association, including American Life and Accident Insurance Company, that I could answer or that I could deal with and he said he had no questions, he had no pending matters, and that there was nothing—that all matters had been taken care of as far

as he was aware. I then asked Mr. Millspaugh if we should continue or I could continue to deal with him in the administration of the rules and he told me he didn't know what the situation was.

I talked to Mr. Henry Miller about the matter. I talked to Mr. Earl Kintner about the matter. I talked to Mr. James A. Horton about the matter. I talked to Mr. Allen Phelps about the matter. I talked to everyone that I could find to discover whether the rules, the trade practice rules, had been rescinded or suspended and I could find no one who said they had been and I could find nothing that said they had. I could find no one who knew or could tell me, and I asked all of them the question, as I asked the Commissioners, what persons, what Bureau, and who to consult in connection with the administration of the trade practice rules relating to the advertising and sales promotion of mail order insurance. I have never yet received an answer and I have even recently asked the question. I could find no one to consult, no one to cooperate. Up to the time of the filing of the complaint I never received any criticism concerning the advertising materials of American Life and Accident Insurance Company or any suggestions or anything as to revisions that should be made in their material.

CROSS EXAMINATION

The Association applied for the rules and assisted in their preparation, drafting and all we could do in assisting the Commission in the promulgation of the rules. The promulgation was by the Commission. The staff of the Commission has always told me that our Association was the sole applicant for such rules. At that time I believe our Association had about 14 to 16 members or member companies. I believe the Commission initiated or considererd the initiation of the conference as a result of the application which Mr. Berge and I made. I will say, however, that one of the Commissioners came to address the members of the Association at the time when it was being considered

whether the Association should apply to the Federal Trade Commission for trade practice rules and urged that course of conduct on them and said that there were many benefits to be derived from that, from application and from trade practice conferences with the Federal Trade Commission. It was likewise also suggested at that time by the Post Office Department as being a salutary thing. The Post Office Department and one of the Commissioners recommended our application to the Commission. As a matter of fact, more than one of the Commissioners. I presume that we applied to the Commission in the right of members of any industry to apply to the Commission and ask the Commission to do something. I would suppose that any citizen, any man in industry, or anyone else has a right to write to the Commission and ask them to do something. I suppose the general right of a citizen to write his government. I do not know whether the application was proper or not within the rules laid down by the Commission for proper application; the Commission considered it, adopted it, and acted upon it. The Association definitely considered itself subject to the rules. All the members who returned the signatory cards and, as a matter of fact, all persons who subsequently joined the Association did the same, considered themselves subject to the rules.

The application to modify the rules or change the rules was both in the nature of changing a substantive portion of the rules and enlarging the scope of the rules. It was to enlarge the scope of the rules in regard to enlarging the number of companies—the number of types of sales that would be covered. The rules as promulgated by the Commission related to advertising which was used without the intervention or personal solicitation of a licensed agent. Therefore it applied only to what may be referred to as in the sale of a policy. Therefore it may be referred to as only mail order advertising where at no point in the sale did a licensed agent come in. The application, at least as far as it related to the scope or further consideration of

the scope of those rules, suggested to the Commission that that advertising which was used by itself and without its being in the hands of a licensed agent and designed for use in personal solicitation should also be incuded. That would include, it intended to include, such material as radio broadcasts or newspaper advertisements or letters or otherwise which were sent out by so-called agency companies for the purpose of eliciting initial inquiries even though they were later followed up by the solicitation of a licensed agent.

This was a request by the Association to the Commission for further consideration in that and other respects. Mr. Millspaugh never made any suggestions about a policy, about changes to be made in a policy, although I do want to point this out to you, that the trade practice rules were well understood by those who drafted them, and I was told so, to cover policies when the policies were included as an advertisement. No one ever doubted that. What I intended to say with respect to what Mr. Millspaugh said was that he suggested changes in the advertising material which it could accomplish in effect by changing the policy or the suggestion which Mr. Millspaugh brought up was met by changing the policy, which is not unusual in advertising, as you would understand, but Mr. Millspaugh never suggested changing the policies themselves, not to me. I certainly understood in submitting applications for trade practice conferences and in taking part in a trade practice conference that there was a possibility that there might at some time be enforcement proceedings initiated by the Commission against its trade practice procedures. I understood it specifically in connection with those instances where you did not follow the trade practice rules. As explained to me the Commission was bound to proceed against those people who did not comply or make any good faith attempt to comply with the trade practice rules that related to them and to their practices. That concept would apply to both member companies who were members of the Asso-

ciation as well as others who became signatories to the rules. It was understood that any company that did not make a good faith effort to comply with these rules that fell within the scope of the rules and their advertising violated the rules, that the Commission could and would and should proceed against them.

Respondent's Exhibit 29

(718)

FEDERAL TRADE COMMISSION
WASHINGTON

Office of the Secretary — March 3, 1954

Mr. Wendell Berge
Mr. A. Alvis Layne, Jr.
Layne and Ephraim
Wyatt Building
Washington 5, D. C.

Gentlemen:

Your letter of February 19, 1954, regarding the current investigation of the accident and health insurance industry has been received by members of the Commission and its contents noted.

Your letter has been referred to Mr. Robert R. Sills, Special Attorney in Charge of the Insurance Division, for his information.

The Commission is mindful of avoiding developments that may not be wholly consistent with the purpose of having the inquiry carried out in a manner that is fair as well as thorough and effective. The members of the Commission believe that you will agree with the soundness of such policy or purpose and will lend your cooperation.

By direction of the Commission.

Sincerely yours,

s/ ALEX. AKERMAN, JR.,
Alex. Akerman, Jr.,
Secretary.

John W. Goodin,

on behalf of respondent, testified as follows (June 7, 1956):

DIRECT EXAMINATION

I am a lawyer. I have been a lawyer since 1949. I am employed by the Missouri Division of Insurance as counsel. My duties are various. I am legal advisor for the Superintendent of Insurance and the other departments within the Division of Insurance. I consult with companies on their corporate affairs. The handling of complaints is exclusively the jurisdiction of the Legal Department and any other duties that are assigned to me by the Superintendent or referred to me by the departments within the Division. I advise in conjunction with the Attorney General of Missouri, the Superintendent in the Missouri Insurance Department, as to the statutory provisions which affect the operations of that Department. I advise with other personnel in the Missouri Insurance Department as to policies and interpretations and legal conclusions to be drawn from policies of insurance. Whenever a problem comes up in any department within the Division that has any legal aspect whatsoever, I am called in on conference on it and am asked to render an opinion. Any complaints as to advertising conducted by companies domiciled in Missouri, that is chartered and licensed by the State of Missouri, come to my part or section of the Missouri Insurance Department. I used the term complaints generically, and it always includes inquiries which, I suppose, are the majority of the contacts the public have with us. I do not recall any complaints received from outside of the territorial limits of the United States but we have received them from all over this country. Many of these complaints or inquiries are received directly from persons resident throughout the United States. Some of them are not. Where they are not received directly from members of the public, one other method of receiving complaints is that they are forwarded to us by the insurance supervisory officials of other states.

That is a common practice among insurance superintendents or commissions in the various states.

When we receive a complaint or inquiry in the Missouri Insurance Department, first we attempt to get all of the facts surrounding the inquiry or complaint. If it is an inquiry, of course we answer the correspondent who's written in. If it is a complaint, we may contact the insurance company involved for a review of their record. We ask them to submit to us either in summary form on some occasions, by photostatic copies, or verbatim recitals of the contents of their files. We ask them to send us the information they have substantiating the position that they have taken which is being complained about. Our investigation has on occasions gone beyond merely the question of submittal of this material in writing. If at all possible we handle the thing to a conclusion through correspondence. Sometimes the correspondence becomes quite weighty and it becomes necessary to call the responsible officers within the insurance company to the Division of Insurance for a conference on the matter.

We have contact with members of the insurance purchasing public other than through correspondence or written materials that come to the Insurance Department. We have quite a substantial walk-in trade there. There is no different treatment whatsoever accorded by us to complaints or inquiries received from persons not resident in the State of Missouri than we accord to those from persons resident in the State of Missouri.

I have been authorized by the Superintendent of Insurance in the State of Missouri to appear at this hearing. As a matter of fact he sent a letter with me to the hearing examiner and, if I may, I would like to deliver it. The letter referred to is as follows:

"STATE OF MISSOURI
Phil M. Donnelly, Governor

"DIVISION OF INSURANCE
"Department of Business And Administration"
Jefferson City

"C. Lawrence Leggett
Superintendent

June 6, 1956

"Honorable Earl Cox
Hearing Examiner
Federal Trade Commission
Washington, D. C.

"Dear Sir:

"I regret that I will be unable to appear at the FTC hearing on the complaints against Automobile Owners Safety Insurance Company and the American Life and Accident Insurance Company, because of the press of business in my office.

"However, I am sending my Counsel, Mr. John W. Goodin, and authorize him to represent me in these hearings. Mr. Goodin is familiar with the procedures followed by my Department in the handling of complaints since these matters are handled under his direct supervision.

"Respectfully yours,

"C. Lawrence Leggett,
"Lawrence Leggett,
Superintendent.

"CLL:mfs"

With respect to the regulation and practices of the Missouri insurance companies, the Department of Insurance of Missouri does the following functions and performs the following types of activities: we regulate them in all phases of their activities. We of course have the examiners who examine into the financial condition and the character of management, the business practices of the insurance companies operating in Missouri. We have a policy forms

analyst who receives and examines and ultimately approves policies of insurance in the accident and health field. We have an actuary who deals with life insurance policies. We have a fire rater with whom the fire policies are filed. We have a workmen's compensation man. We have the agents' licensing division. We have the evaluation section, which computes the reserves on policies. In every phase of the insurance business the Missouri Division of Insurance regulates things. The examiners are full-time employees of the Department. The examination of the affairs of the Missouri insurance companies is conducted every three years. In these periodic examinations the examiners review the claim payments, claim administration, of the company under examination. They go thoroughly into all of the Division's practices, which of course includes the processing and mailing of complaints. There is at least a sampling of the claims files to determine whether a more extensive examination is necessary. I would like to correct an impression that I gave that is probably erroneous. I said that the companies are examined every three years. They are examined at least every three years, and if occasions warrant they are examined more frequently. The Missouri Department has the power to examine an insurance company at any time when deemed necessary by the Superintendent of Insurance, including the officers. We certainly have the power to take action in cases where an examination by the examiners indicate that claims have been unfairly or improperly denied, although I think the question is moot. To my knowledge there have been no discoveries of a practice of any insurance company to unfairly deny a claim. In the event that an individual claim comes to the attention in this review by an examiner of the Department without regard to it being a practice which is unfairly in his judgment or in the judgment of the Department been unfairly denied, that is brought to the company's attention. I do not think the Department makes a definite order that the claim be paid. The usual procedure

in a circumstance like that is to collect more information with regard to the claim on which they can base a determination. If there is a very serious question of fact existing, we do not consider that an unfair denial of benefits, but we have the power to order the payment of an individual claim if the proofs of loss bring it clearly within the terms of the policy. The Missouri Department takes action with respect to the interpretation of the policies. We do not permit our companies to stand on technical defenses within their policy. I do not recall an instance of having been consulted as to the meaning of policies and terms and conditions as a result of an examination, but certainly from clients coming into the office I am consulted.

I have very, very frequently reviewed in the course of my work accident and health policies of insurance companies licensed to do business in Missouri. Such examination has included policies of companies that may be domiciled elsewhere than in Missouri as long as they are licensed to do business within the State of Missouri. It is the opinion of the Missouri Division of Insurance that we do have authority to regulate and supervise advertising used by insurance companies domiciled in Missoari. It's the opinion of the Division of Insurance that it extends to every form of advertising that can be used by a company. It is the opinion of the Division of Insurance that this power extends to advertising used by Missouri domiciled companies—that is companies chartered and licensed in Missouri—wherever disseminated by them in the United States and it's been so used. If a Missouri company has insureds in a state in which it is not licensed, we require the company to be subject to service of process within that state by the filing of a power of attorney. American Life and Accident Insurance Company has on file such powers of attorney. Those are on file to the best of my knowledge in every state in which the company does business.

It's the opinion of the Missouri Division of Insurance that we in fact regulate and supervise the advertising used

by the Missouri domiciled company. That is carried out as follows: There is no pre-censoring of advertising, that is we do not require the companies to get prior approval from the Division of Insurance of any advertising they propose to use. There are statutes that prohibit false and misleading advertising and if we receive a complaint or if by my men it is brought to our attention that one of our insurance companies is as a matter of fact using false and misleading advertising, we take whatever action is indicated in the premises by conference with the company seeking, tending toward the elimination of the use of the offending advertising. To date it has not been necessary to impose any penalties or sanctions against our companies. Missouri has issued a regulation or direction to Missouri companies with respect to advertising practices. A letter was sent from the Division of Insurance to the companies licensed there with relation to advertising pointing out pretty much what I just said that the advertising is the concern of the companies, that they proceed in that manner at their own risk knowing the provisions governing their advertising. We expect them to censor their own advertising, and if they do transgress they, of course, realize that they will be subject to the penalties of action by the Division of Insurance.

It is the instruction of the Superintendent that all inquiries or complaints from the public sent either directly or through other departments from persons within the United States, members of the public, with respect to the advertisements of American Life and Accident Insurance Company, come to me. If it doesn't come initially, it is referred to me by the other departments who may receive it. The Missouri Insurance Department has not received, beginning in 1953 through the year 1953 to date, any complaint from any member of the public with respect to the advertising material that has been received as Commission's exhibits in this case.

I said that there is a practice or policy in the Missouri Insurance Department of not permitting the Missouri com-

panies to rest on technical defenses and denial of claims. With reference to certain provisions of the policy identified in this case as Commission's Exhibit 42, referring to the top left-hand corner of the second page, where you find a reference to benefits for accidental death, there is a provision which refers to 90 days. We think that is a technical provisions. It is permitted as a defense to the companies from fraudulent claims. If the ultimate loss results solely from the accidental bodily injury, regardless of the 90 day period, if the loss can be completely tied in with the accidental occurrence, the company will not be permitted to stand on the 90 day provision. Let may say first of all, we would probably receive a complaint or inquiry if a company tried it. I remember no specific instance on the 90 day period but on some of the other technical, as I call them, defenses when a policy complaint has been made to the Division of Insurance we take action without forcing the insured into court. If the time limit, the technical defense, is the only item on which the company denies liability for the claim, we order them to pay the claim. Such a provision as that referring to 90 days, Commission's Exhibit 42, is not unusual.

I have read the advertisements received in evidence as Commission's exhibits. It is the opinion of the Division of Insurance under all of our procedures and practices that those documents are not misleading to the public or deceptive.

CROSS EXAMINATION

The basis for my statement with regard to the advertising of this particular company that our Department has never received any complaint about the advertising of this company is the fact that the Division of Insurance has not received complaints about the advertising I have examined in the record of the two cases here. I have looked through our records. There has been no complaint made about the advertising.

The contact our office has with the advertising which is being disseminated by the Missouri licensed corporations comes from various sources. Perhaps an illustration will best describe just exactly what contact our office has. It frequently happens that when an insured has a complaint as to the treatment of his claim, he will write to the Division of Insurance with that complaint. Now on some of the letters we receive enclosed with his complaint will be a various number of documents. There may be premium receipts, there may be pieces of advertising material, there may be a return address cut from an envelope serving many functions, one, to identify without any possibility of error the identity of the insurance company involved. Now in the process of claim complaints, the complaint arises first of all because the company has not paid the insured. The Insurance Department is of the opinion that he is entitled to payment for the occasion giving rise to the claim. Now in these occasion he will say, "I was led to believe that it would be covered because of what the company told me, what I received in the mail from the company." Most frequently it is the oral representation of an agent. In those instances where the claim and the treatment of the claim has a direct bearing to the reference to advertising accompanying it through correspondence, the insurance company is contacted relative first to the handling of the claim. We like to see their file, what they have done, and what their basis for doing what they have done is, what they have within their file that justifies their action, and then if that does not resolve the complaint, it still appears that there is misrepresentation and reasonable grounds for misrepresentation, that is worked out again with correspondence or if necessary a conference with the company. If the material sent into our Division by a complainant in this instance, and parenthetically, let me say I don't recall of any particular instance where we have received a piece of advertising material from a member of the purchasing public with a letter saying, "This led me to buy a policy of

insurance; I have been misled; the advertising is wrong". I may be creating a false impression right there and I will come back to that. Remind me, I want to clear that one up. If the advertising they send in is in our opinion calculated to mislead the people, if it is misleading, if it does not fairly represent the provisions of the policy that it is supposed to describe, we will call the company in and through conference eliminate the objectionable features. It is conceivable that on some of these occasions we will be too close to the forest to see the trees ourselves. It might be in some occasions we have been convinced that we are concentrating on a particular item within the piece of advertising under question to the exclusion of the overall picture created by the entire piece of advertising. But in these discussions with the company that is worked out. If it appears, that is, if they can convince us that it is not misleading, they are told to discontinue its use. It invariably happens that they do discontinue its use.

Now back to the false impression that I may have created. On a few occasions we have had people write to the Division of Insurance and say "I have purchased such and such a policy and it has not been as represented to me." Again most frequently it is the result of oral representation from an agent. Occasionally it happens on advertising material. They will say, "I no longer want the policy. I want my money back." In those instances we write to the insurance company, tell them that the holder of the policy has claimed misrepresentation, that they are dissatisfied with the policy, and make request for refund. In those instances where the insurance company has not been involved on the risk for any appreciable period of time, the company without question makes refund of premium and cancels the policy as of issue date. Of course, in those instances where the policy has been in force for a period of months, the insurance company assumes, and the Division of Insurance recognizes the validity of that assumption, if the claim has arisen during that period, the policyholder would have

insisted upon payments of the benefits provided by the policy. They have figured they have given the protection. Therefore we resist the refund of the premium. We have earned the premium charged for it. Unless and until it is conclusively proved that this particular insured was misled by some reason, either written advertising or oral representation, into the purchase of the policy, if it can be proved by these facts, even then they will make refund. Of course, we have approached that problem with the theory that the insured has a certain duty also with relation to his policy of insurance. It is of course a contract. They are assuming a legal relationship with an insurance company. We think it is incumbent upon them to read their policy when they receive it and at that time check it with the impressions they have concerning it. If it does not measure up at that time, clarify it. It can be done either that they get the type of policy they want or that they get a refund of their premiums. That has been rather detailed. It has been a couple of examples. I hope it has answered it.

I stated that generally or frequently the advertising material claimed of might be connected in some way with a claim which was not paid according to the policyholder's satisfaction. I have not looked at every correspondence file concerning this company. A facetious reference to the testimony of this morning, I have made a sampling which I think is a fair sampling of the correspondence in our files and based on that I would say that there has been no complaint on advertising. I am not prepared to say categorically that there has been none involving a claim which might have been based upon advertising of the company. In several of the claim correspondence files the advertising material shows up. In some instances there has been no particular reference to the advertising material. It may have been in there merely to identify the company. It may have been in there that that is what induced them to purchase. I might amplify what I have already said. In those instances where a complaint does involve advertising, that

is a claim complaint does involve advertising, and the advertising can be construed to create in the mind of the insured the impression he had as to the coverage he had, the companies are urged and cooperate in paying the claim according to the tenor of that understanding if it is not a totally outlandish, far-fetched interpretation. We have several legal means available in our office to enforce the payment of that claim. We have, of course, the insurance code. We have the general law, the general statutory law on misrepresentation. We have through procedures and practices that have been built up through the experience of the Division of Insurance over a long period of time what is generally referred to within the Division as a police power. There is some case law in the State of Missouri that also refers to the power of the Superintendent in his supervision of insurance companies. Now among the statutes within the code we have, of course, the power to examine insurance companies not only as to their financial solvency but also as to their conduct of their affairs, their management. We have a section in the statutes which permits the Superintendent of Insurance to initiate proceedings to wind up an insurance company under several things appearing to him as the result of examination or other examination. And one of them is that if the Superintendent finds that the company has violated the law, he may initiate such proceedings. Of course, the general law of misrepresentation, if that has been violated, he would have the authority to step in. Another general power given in the section relating to winding up the affairs of a company is if in his opinion, based on information coming to him, the continued operation of the insurance company would be hazardous to the public, he has the right to step in and wind up its affairs. Now the power to examine carries with it in our interpretation the power to correct any abuses in those areas in which we are empowered to examine that that examination brings to light. Otherwise, it is a useless power. It does no good to find

out if you can't do anything about it. And it is a power affirmed by the Division of Insurance through its practices and procedures over a long number of years in which the companies acquiesce without raising any objection.

There have been no normal hearings called for the enforcement of any regulations dealing solely or primarily with advertising. There have been no cease or desist orders issued with relation to advertising, although it is our opinion that we have the power to do both. It has been handled through means of conference based on the theory of the Division of Insurance that our function is to administer the law for the protection of the policyholders. Now we feel that a formal citation, for instance the calling of a formal hearing, would with the attendant publicity substitute for the harm to be corrected a greater harm in that the confidence of the people in the insurance furnished by that particular company and in all insurance will be weakened by the publicity on this particular one item, and as I say we have never been forced to the issuance of a formal cease and desist order. Nor have we been forced to wind up a company if, after our conference and our recommendation to the company that it stop the practice it has been following either with relation to advertising or many of the others, if they then in the face of our recommendation persist in the action which we have found bad or—now this is prospective because it has not happened—but if it appears in our conference that their action has been willfully taken with an intention to evade or violate the law, then of course it would be not only our right but I think our duty to step in and at least remove from the active management of the company those who have caused those bad practices to be followed. We have found the conference method a very satisfactory means of proceeding.

With regard to complaints regarding advertising being disseminated by companies domiciled outside Missouri but licensed in Missouri, we use the same method of enforcement as with reference to companies domiciled in Missouri

and licensed in Missouri. It isn't always necessary for a personal conference with the officials of the out-of-state company. Sometimes it can be done through correspondence. However, we have very little difficulty in getting officials of insurance companies licensed in Missouri, wherever they might be domiciled, to come to Jefferson City.

Supposing we have a complaint with regard to a mail order insurance company which is domiciled in the State of Delaware. There are perhaps alternate procedures by which the Superintendent's office of the State of Missouri would go through to prohibit that type of advertising within the State of Missouri. If it occurs in the same fashion as it does the complaints we receive, that is the advertising as part of a claim complaint, we all either write to the person who has written to the Division of Insurance and instruct them to write to the Insurance Commissioner of the state of domicile of the offending company with regard to the claim or we within the Division of Insurance will forward the complaint with whatever enclosures might be with it to the Commissioner of Insurance in the state of domicile of the offending company.

With regard to the particular advertising involved in this proceeding, it is rather difficult to say when this advertising was first brought to my attention. Some of the individual pieces I have seen before. Some of them were brought to my attention for the first time last night on the way here to Washington. The circumstances in which I would have seen the pieces prior to coming to Washington last night were on their having been sent to our office by members of the public. It is not always in one relation but in several relations that they were sent to our office. It is not infrequent that we will receive an inquiry concerning an insurance company and this insurance company. The inquiry will have enclosed with it the piece of the advertising that is in evidence here. If it is an inquiry concerning the company enclosing the advertising, that does not in every instance necessarily mean that I, as a matter of

course, inspect that advertising. If it is a piece of advertising that I have seen before, I pay no particular attention to it unless the inquiry itself is connected directly with the piece of advertising. It is a rather rare instance that we get a letter from a member of the public which involves simply a piece of advertising. Probably by far the vast majority are routine inquiries about various companies doing business within the State of Missouri. I can't give a definite answer as to how long it has been the policy of the Superintendent's office to direct the companies not to stand on the particular technical defenses pointed out on direct examination. It has been since I have been there and it is my understanding—it certainly is something that I did not initiate. Whether it can be pegged to the particular section authorizing examinations or not, our usual reference to it in the Division of Insurance is that it is within the police powers of the Division of Insurance. It is true that the police powers of the Division of Insurance don't specifically set forth this ability to insist that the company not stand on its technical defenses. I can't say when that policy first started because I don't know. It has been a policy of the office since I have been there and it is something that I did not initiate. It was there when I came in. There are very few cases of disagreement between the company and the Superintendent's office as to what is a technical defense within the contract. First of all, there are very few cases of complaint on what we are calling technical defenses. Ordinarily, if the technical defense is the only defense that an insurace company has to claim, it pays the claim prior to any complaint to the Division of Insurance, so we have none. If it appears on an investigation of the facts that one of these technical defenses is involved together with some other fact issues, we of course do not tell the companies not to stand on its technical defense. Our theory is that these technical defenses are protections which the insurance company is permitted to erect around itself through its contracts to protect itself

from fraudulent claims. Not every claim that is sent to an insurance company is a legitimate one.

I personally engage in conversations and interviews with these people or with anyone who might come in to question the treatment of a company on a particular claim because of some conception that they might have with regard to the policy due to the company's advertising. I do that in the normal and regular course. Very few of these are based upon what I term the technical defenses outlined in the policy. The majority of them are concerned with the fact that their claim has not been paid. Probably the most frequent cause of complaint in the handling of a claim is prior origination of the condition. Now whether the insured claimant complainant has from the advertising itself an understanding that the insurance policy will cover every condition that he may have had in the past or in the future or whether it is a failure on his part to understand that a condition originates at the time it first manifests itself by symptoms and not necessarily the first time he goes into the hospital to have cut out, there is a misunderstanding and in those instances frequently advertising—and I will say this, not particularly written advertising but representations of agents—are a matter of discussion.

Rulings Excluding Evidence

[Tr. 598] * * * Q. Now, Mr. Goodin, in Exhibit No. 42, page 2 of that exhibit, do you see in the lower right hand corner of that Exhibit on page 2, a reference to exclusion for hospitalization as a result of war, or act of war?

A. Yes, sir.

Q. Can you tell us whether, in your experience that such a provision—whether such a provision is an unusual provision.

MR. MAYER: I object to that. That has no relevancy to the proceeding, whether it's a usual or unusual.

MR. LAYNE: I'm prepared to argue that.

HEARING EXAMINER COX: Let's hear it.

MR. LAYNE: This proceeding involves a respondent that was subject to and signatory to the trade practice rules of

the Federal Trade Commission heretofore issued by the Commission and to which evidence has been adduced the respondent in here during the course of the cross examination of the witness with respect to that, it appears to me that some issue was made as to whether or not the respondent did, in fact, [Tr. 599] in good faith, comply with those rules, which I think is a relevant matter, to this proceeding, and particularly to the Commission's ultimate determination of the matter.

I'm attempting to show that the provisions of the policy as to whether it is contended that this company misled and deceived the public, were not unusual provisions, which, under the trade practice rules, apparently still are in existence, did not require or direct the advertisement of such provisions; and, matter of fact, used precisely that language. I think it's relevant for that.

I think it's also relevant on further grounds. I think that this Commission has not accumulated the body of experience in this field of insurance, and in determining whether members of the public in such a proceeding as this are likely to be, or would be, in the judgment of the Commission, misled or deceived, or whether the material has the tendency or capacity to do that is, itself, relevant as to whether or not this is an unusual provision. That is, one that would not usually be in such policy.

On those two grounds, I think the question is relevant, and I think the answer should be admitted.

Hearing Examiner Cox: Do you have any further comments, Mr. Mayer?

Mr. Mayer: No, sir, I have no further comment.

Hearing Examiner Cox: It seems to me, Mr. Layne, [Tr. 600] that we're not called upon in this action to interpret the trade practice rules as they relate to health and accident insurance business.

The second ground that you have urged in support of your question goes to the interpretation that the public might put on the advertising and you come right up to the

point of the proposition that was suggested by Mr. Mayer awhile ago, which is whether deception is actionable if it's limited to a few individuals or whether it must be to a number of persons, and I gather it's the contention of counsel in support of the complaint—and certainly it's been indicated in the decisions, some of the decisions of the Commission—that the deception of any part of the public is sufficient to warrant the issuance of a Cease-and-Desist Order.

I think I'm going to sustain—I'm going to sustain the objection. However, you may, for the purpose of protecting your record, make an offer of proof as to what the witness would have answered.

MR. LAYNE: Thank you, sir.

Preserving my position, I would like to make the following offer of proof: The witness, if permitted to answer that question, would answer that the provision was not an unusual provision in hospitalization and accident and health policies, and would like to ask the witness the following question:

[Tr. 601] Do you see, likewise in the lower right hand corner of page 2 of that document, Exhibit—Commission's Exhibit 42, Docket 6238, American Life and Accident Insurance Company, a reference to suicide, or attempted suicide while sane?

THE WITNESS: Yes, sir.

By MR. LAYNE:

Q. Now, with respect to that provision in that policy, does that arise as a result of a somewhat unique situation under Missouri law?

A. Yes, sir.

Q. What is that unique situation?

A. Under Missouri law, suicide, or attempted suicide, while insane is considered an accident.

Q. Now, could you tell me whether or not—can you tell me whether or not, in your experience, such a provision as

excluding payment of benefits in the event of suicide or attempted suicide is a usual or unusual provision in accident and health policies, including hospitalization policies?

MR. MAYER: Same objection, Mr. Examiner.

HEARING EXAMINER COX: That would be the same ruling. You may make an offer of proof, Mr. Layne.

MR. LAYNE: I offer to prove that that if the witness were permitted to answer, he would have testified that that was not an unusual provision, that it was a usual provision.

By MR. LAYNE:

[Tr. 602] Q. Now, Mr. Goodin, calling your attention again to the same exhibit, and to the reference in that exhibit of exclusion when the insured is under the influence of alcoholics, intoxicants, narcotics, unless administered on the advice of a physician, I'd like to ask you whether or not that provision is an unusual provision in accident and health insurance policies, including hospitalization policies?

MR. MAYER: Same objection.

HEARING EXAMINER COX: All right, same ruling. Go ahead.

MR. LAYNE: I offer to prove by this witness that if permitted to answer, that he would testify that it was not an unusual provision. I'd like to also call your attention, Mr. Goodin, to the provisions of the same exhibit which exclude payment for hospitalization due to mental disease or to derangement, or to nervous illness, and ask you whether or not that is an unusual or a usual provision in an insurance policy and accident and health insurance policy, including the hospitalization policies, in your experience?

MR. MAYER: Same objection.

HEARING EXAMINER COX: Same ruling.

MR. LAYNE: I offer to prove that if the witness were permitted to answer, he would testify that it was not an unusual provision.

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15828

AMERICAN LIFE & ACCIDENT INSURANCE COMPANY

v.

FEDERAL TRADE COMMISSION

Petition for Review of an Order of the Federal Trade Commission

---

American Life & Accident Insurance Company, a corporation, by its attorneys, presents this its petition to review and set aside an order of the Federal Trade Commission, entered in the *Matter of American Life & Accident Insurance Company*, Federal Trade Commission Docket No. 6238, on April 18, 1957 and served on petitioner on April 30, 1957.

NATURE OF PROCEEDINGS AS TO WHICH REVIEW IS SOUGHT

The proceedings as to which review is sought arose out of a complaint for an order to cease and desist and a notice of hearing, issued by the Federal Trade Commission pursuant to Section 5(b) of the Federal Trade Commission Act (38 Stat. 719, as amended, 15 U.S.C. 45(b)) on October 14, 1954 and served on petitioner on October 17, 1954. The complaint alleged that petitioner was engaging in unfair or deceptive acts or practices in interstate commerce in the sale of a certain policy of accident and sickness insurance in alleged violation of Section 5(a) of the Federal Trade Commission Act. The allegedly unfair or deceptive acts or practices consisted of the broadcasting of certain radio advertisements, and the mailing of certain written

advertisements, to various members of the public, which advertisements were alleged to contain statements misrepresenting the terms of the insurance policy. The proceeding was one of about 41 such proceedings brought by the Commission, alleging similar practices by accident and health insurance companies.

In due course petitioner appeared and showed cause why an order to cease and desist should not be entered by the Commission. Hearings were held before a hearing examiner of the Commission, in which testimony was taken and reduced to writing and exhibits were received in evidence. Upon such hearing, the Commission's hearing examiner was of opinion that no order to cease and desist should be entered; he therefore entered an initial decision, in writing, dismissing the complaint. Thereafter, the Commission, reversing the order of its examiner, made a report in writing stating its findings as to the facts, to the effect that petitioner's said acts or practices had been misleading or deceptive, and caused to be served on petitioner a final order to cease and desist from using advertisements containing certain described language. Review is sought of that order.

Jurisdiction and Venue

The Commission's order to cease and desist was served on petitioner on April 30, 1957. The jurisdiction of this Court is invoked under Section 5(c) of the Federal Trade Commission Act (38 Stat. 719, as amended, 15 U.S.C. 45(c)).

Petitioner resides and carries on business within the Eighth Judicial Circuit, in that petitioner is a corporation organized and existing under the laws of Missouri, having its principal place of business at St. Louis, Missouri. The acts and practices in question were used within the Eighth Circuit in that the advertisements alleged to contain the alleged misrepresentations were written and broadcast or mailed, as the case may be, within the State of Missouri.

Grounds on Which Relief is Sought

The grounds upon which relief is sought center around three kinds of errors committed by the Commission, as follows: (1) errors involved in the Commission's refusal to give effect to or to permit petitioner to rely on the Commission's own substantive regulations, known as Trade Practice Rules, which purported to specify the proper content of advertisements used in petitioner's industry and with which petitioner was at all relevant times in full compliance; (2) errors involved in the holding that petitioner's voluntary institution, before commencement of the proceedings below, of the practice of mailing a copy of its policy with all of its mail advertising did not amount to an "abandonment" of the allegedly unlawful practices (within the meaning of the settled doctrine that such an "abandonment" warrants dismissal of the proceeding where, as the Commission here conceded, there is little likelihood that the abandoned practices will be resumed); (3) errors in holding, contrary to the evidence, that petitioner's advertising, both before and after petitioner's institution of the practice of setting forth the policy in full, was misleading and deceptive. A brief statement of the circumstances of these holdings may clarify the nature of the errors. Thereafter the errors will be specified in detail.

I. The Commission's Errors in Holding Its Own Controlling Regulations Irrelevant

1. For many years the Commission has had a practice of promulgating, at the instance of members of an industry or otherwise, so-called Trade Practices Rules. These are in the nature of substantive rules or regulations, promulgated in the exercise of the Commission's implied powers under the Federal Trade Commission Act, to define various unfair methods of competition or unfair and deceptive acts or practices in the terms and circumstances of the particu-

lar industry, "for"—in the Commission's words—"the guidance of businessmen."[1]

2. Such Trade Practice Rules are enacted pursuant to procedures set forth in the Commission's Rules of Practice, which conform closely with the procedures for rule-making set forth in Section 4 of the Administrative Procedure Act (60 Stat. 238, 5 U.S.C. 1003). The procedures include provision for petitions by the public, notice and public hearings on proposed rules, and publication in the Federal Register of the rules adopted.

3. Petitioner in 1948 participated in a group which applied to the Commission for such rules for petitioner's industry, known as the mail order insurance industry. In due course, after the specified procedures, such rules were promulgated and published, on February 3, 1950 (15 Fed. Reg. 599). They remained in effect until their repeal on August 22, 1956 (21 Fed. Reg. 6332), at which time the proceedings below had been pending for almost two years. These regulations defined unfair and deceptive practices in insurance advertising of the kind used by petitioner. By implication, advertisements which complied with the rules were free from deception in the respects dealt with by the rules.

4. Pursuant to established practice, members of the industry, including petitioner, signified their adherence to these Rules. Also following regular practice, the Commission undertook, through its staff, the duty of examining advertisements, submitted to it by adherents to the Rules, with a view to advising the latter as to their compliance with the Rules. Petitioner's advertisements—the very advertisements on which the present order is based—were thus examined on several occasions; suggestions were sometimes made by the Commission for revisions in certain

[1] Section 2.21, Rules of Practice and Procedure, Federal Trade Commission.

respects; the suggestions were adopted; and the advertisements were pronounced unobjectionable by the Commission.

5. The practice of cooperative submittal and approval was being carried on actively by the parties, when, without notice or warning, without repeal or amendment of the regutions, without any prior disapproval of petitioner's advertising, and without any complaint against petitioner from any public source, the Commission instituted the proceeding of which review is now sought, alleging deception in the very advertisements which it had previously approved.

6. In the course of the proceedings below respondent sought, by appropriate procedures, to obtain from the Commission's documentary files and by testimony of the Commission's personnel, evidence showing that petitioner's advertising was and had been in compliance with the Trade Practice Rules. The Commission, by an interlocutory order, refused petitioner access to such evidence, holding the compliance of petitioner's advertising with the Rules to be irrelevant. Thereafter the hearing examiner rejected, in reliance on such order, all offers by petitioner of evidence that the advertising statements complained of were proper under the Trade Practice Rules.

7. Petitioner submits that the Commission's holding and the rulings thereunder were erroneous in that the Trade Practice Rules are substantive regulations, binding on the Commission as well as on the petitioner, which may not be altered or amended by the Commission, except in accordance with its rule-making procedures, and, even then, not retroactively. If petitioner's advertising was, under these Rules, not unfair or deceptive, the Commission could not validly find to the contrary. Therefore, deprivation of petitioner's opportunity to prove compliance with the regulations requires reversal.

II. Errors in Holding That the Facts Did Not Amount to Abandonment

1. The Commission and the Courts of Appeals recognize a doctrine of law to the effect that, although a party has engaged in practices violative of the Federal Trade Commission Act, nevertheless the violation does not warrant the issuance of a cease and desist order if the party has voluntarily abandoned the practices in circumstances which indicate that there is no likelihood of its resuming them after dismissal of the proceeding.

2. Petitioner presented evidence below that it contends demonstrated such a voluntary abandonment of the practices complained of. Petitioner also presented evidence of its history of cooperative dealing with the Commission under the Trade Practice Rules, as described in Part I above, contending that this evidence tended to establish its propensity to abide by whatever the Commission might state the law to require, without the need to be bound by a cease and desist order. On the basis of this evidence petitioner sought dismissal under the doctrine stated above.

3. The Commission, in its decision, acknowledged the doctrine and conceded, at least for the purpose of argument, that the dealings under the Trade Practice Rules established petitioner's propensity to comply with the law, but held that dismissal was not warranted because there had been no abandonment of certain of the allegedly unlawful practices. This conclusion was based on inference from undisputed facts, as follows:

4. The practices here in issue consisted of the inclusion of certain allegedly misleading and deceptive statements in its mail advertising. The mail advertising, as originally carried out, consisted of sending to prospective purchasers of petitioner's policy a series of form letters, enclosing a brochure, application blanks, and return envelopes. The form letters referred the reader to the brochure. The Commission complained that certain excerpts from the let-

ters and certain excerpts from the brochure were false and misleading. Petitioner's voluntary modification of its practices consisted in withdrawing the brochure from use and substituting for it a specimen copy of the insurance policy being offered, the form letters remaining unchanged, so that the reader was referred to the enclosures, including the policy.

5. Some of the excerpts complained of were found by the hearing examiner, upon the basis of a comparative reading of the advertisement and the policy, not to be misleading or deceptive. Others, he found, were deceptive in the absence of further disclosure of the limitations, exclusions, and exceptions of the policy; but, he further found, the deception could be eliminated by making the requisite additional disclosures. This, he concluded, was done by the practice of enclosing the policy, which necessarily eliminated all the improper statements that the brochure had contained and which necessarily disclosed all facts about the terms of the policy. He therefore held that an abandonment had occurred.

6. On appeal, the Commission reversed this holding, on the ground that, in its reading of the advertisements and the policy, disclosure to the reader of the previously unadvertised exceptions, exclusions, and limitations of the policy was not sufficient to eliminate the possibility of the public's misunderstanding the passages complained of. Thus, it concluded, advertising in terms of the letters supplemented by the policy constituted no abandonment of the earlier practices.

7. Petitioner submits that in this the Commission erred, because, considering the allegations of misrepresentation in the terms and context of the specific advertisements complained of, it must be held as a matter of law that the combination of letters and specimen policy was not deceptive. This can best be established by a review of the charges and the evidence relating to them, which cannot be conven-

iently undertaken in this petition and must be reserved for petitioner's brief. Taking it as established, petitioner's institution of the combination was an abandonment of the previous practices.

III. Errors on the Merits

1. Finally, the Commission predicated its underlying finding of the unlawful character of the prior practices on nothing more than its own reading of the advertisements and the policy. This reading resulted in its attributing to the advertisements the power to create in the minds of the public "impressions" of the terms of the policy contrary to the actual terms, although such "impressions" in no instance comprised the literal import of the questioned advertisements. The Commission's findings were supported by no evidence as to the public's actual or probable "impressions" of the advertising and no evidence of dissatisfaction on the part of the public with the advertising, and were made in the face of expert testimony to the contrary presented by petitioner.

2. The terms and circumstances of the particular findings cannot readily be set forth without consideration of the record as a whole, but petitioner submits that the Commission's findings in this respect are not supported by substantial evidence on the whole record and, indeed, that the Commission erred in undertaking to make any findings, unsupported by extrinsic evidence, as to "impressions", other than their literal import, created in the minds of other persons by written advertisements.

IV. Specification of Errors to Be Urged

In the light of the foregoing, the errors may be specified as follows:

1. The Commission erred in failing to hold that petitioner's compliance with the Trade Practice Rules required dismissal.

2. The Commission erred in excluding evidence that the advertisements complained of were in compliance with the Trade Practice Rules.

3. The Commission erred in failing to hold as a matter of law that the petitioner had voluntarily abandoned its allegedly unlawful practices.

4. The Commission erred in finding as a fact that petitioner had not voluntarily abandoned its allegedly unlawful practices.

5. The Commission abused its discretion in failing to dismiss the proceeding under the doctrine of "abandonment".

6. The Commission erred in failing to hold as a matter of law that petitioner's practices were neither unfair nor deceptive.

7. The Commission erred in finding as a fact that petitioner's practices were unfair and deceptive.

8. The Commission erred in issuing a cease and desist order against respondent.

Relief Prayed

For the foregoing reasons, petitioner prays that the Commission's order to cease and desist should be reversed and set aside. If the Court is of the view that the Commission erred as alleged in its holdings on the isssue of whether petitioner's practices were unfair or deceptive or that the Commission erred as alleged with reference to the doctrine of abandonment, judgment of dismissal should be entered. If the Court is of the view that the Commission erred as alleged with respect to petitioner's compliance with the Trade Practice Rules, judgment of dismissal should be entered, or, in the alternative, the proceeding should be remanded to the Commission with

directions to make available to petitioner and to permit petitioner to present evidence of such compliance.

Respectfully submitted,

s/ A. Alvis Layne, Jr.
s/ T. S. L. Perlman
Pennsylvania Building
Washington 4, D. C.

s/ Kenneth Teasdale
Cobbs, Armstrong, Teasdale & Roos
506 Olive Street
St. Louis 1, Missouri
Attorneys for Petitioner

[Caption omitted]

Docket Entries

Respondents

American Life & Accident Insurance Company, 3805 Lindell Boulevard, St. Louis 8, Mo.

Complaint Served	10-20-54
Answer Filed	12- 3-54
Initial Decision Served	10- 8-56
Commission Decision Served	5- 1-57

* * * * * * * * * *

12-3-54 Hearing Examiner's order receiving and incorporating into the record answer and motions by respondent.

Served:
A. Alvis Layne, Jr.—12-7-54

12-3-54 Motion by respondent to dismiss complaint, or, in the alternative that complaint be dismissed and matter referred to Bureau of Consultation of the Commission for disposition under cooperative procedures of that Bureau.
(contained in answer filed 12-3-54)

12-13-54 Hearing Examiner's order denying motion by respondent to dismiss complaint and postponing initial hearing set for December 14, 1954, to January 17, 1955, 10 a.m., Washington, D. C.

Served:
A. Alvis Layne, Jr.—12-15-54
Wendell Berge—12-15-54

* * * * * * * * * * *

11-16-55 Application to the Commission by respondent for release of certain information.

11-18-55 Motion by counsel supporting complaint to quash subpoena duces tecum directed to Robert M. Parrish.

Served:
Layne & Ephraim—11-23-55
Wendell Berge—11-23-55

1-11-56 Order denying application by respondent for release of certain information.

Served:
Layne & Ephraim—1-16-56
Wendell Berge—1-14-56

* * * * * * * * * * *

9-25-56 Hearing Examiner's Initial Decision and order dismissing complaint, without prejudice.

Served:
CSC (McLangton)—10-4-56
CSC (Mayer)—10-4-56
Layne & Ephraim—10-5-56

10-15-56 Notice of appeal by counsel supporting complaint from hearing examiner's initial decision.

Mailed:
American Life & Accident Insurance Company—
Layne & Ephraim

* * * * * * * * * * *

4-19-57 Order granting appeal by counsel supporting complaint from hearing examiner's initial decision. (contained in final order issued 4-19-57)

4-19-57 Final order: Findings as to the facts, order to cease and desist and order to file report of compliance.

(Portion of findings from initial decision adopted)
Opinion—Commission—Attached.
Opinion—Gwynne and Tait concurring—attached.

Served:
Layne & Ephraim—4-30-57

6-27-57 Petition to review—(filed by American Life & Accident Insurance Company)
(for Court record, see Sheet 3)

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15828

AMERICAN LIFE & ACCIDENT INSURANCE COMPANY, *Petitioner*,

v.

FEDERAL TRADE COMMISSION, *Respondent*.

On Petition for Review of a Decision of the Federal Trade Commission

PRESS OF BYRON S. ADAMS, WASHINGTON, D. C.

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United States Court of Appeals

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On Petition for Review of a Decision of the Federal Trade Commission

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SUPPLEMENTAL RECORD

Rulings Excluding Respondent's Exhibit 22-C

[Tr. 486] * * * We have here exhibits I would like to have marked for identification.

[Tr. 487] HEARING EXAMINER COX: All right. Will you have the reporter mark those consecutively, beginning with Respondent's Exhibit No. 3 for identification?

Off the record.

(Discussion off the record.)

HEARING EXAMINER COX: Back on the record.

If you will state for the record, please, a description of each of those exhibits that have been identified, it will be appreciated.

* * * * * * * * * *

[Tr. 492] * * * MR. LAYNE: Respondent's Exhibit for identification No. 22-A is a letter dated July 7, 1952, signed by Frank M. Rasada. Respondent's Exhibit for identification No. 22-B is a radio commercial, headed Commercial No. 2. Respondent's Exhibit for identification No. 22-C is a radio commercial, headed Commercial No. 1.

[Tr. 493] (The letter, dated July 7, 1952, Commercial No. 2, and Commercial No. 1, were marked Respondent's Exhibits 22-A, 22-B, and 22-C respectively for identification.)

* * * * * * * * * * *

[Tr. 522] * * * THE WITNESS: Respondent's Exhibits for identification 19 through 25 consist of letters of transmittal from the Company transmitting to me copies of the revised advertising material and the policy forms.

(The papers referred to were marked Respondent's Exhibits 19 through 25 for identification)

HEARING EXAMINER COX: Which is the material you said you had taken to Mr. Millspaugh.

THE WITNESS: Yes; which I then delievered to Mr. Millspaugh.

HEARING EXAMINER COX: Objection to those exhibits will be sustained.

Commission's Exhibit 38

COMMERCIAL #1

Friends, The American Life & Accident Insurance Company of St. Louis, Missouri celebrated their 25th year in business by instituting one of the best hospitalization plans in existence. This new policy is called the NEW PROVIDER POLICY, and it is available to you for only $1.00 per month. All you have to do is send your name and address on a post-card to HOSPITAL PLAN in care of Radio Station .....

and we will send you by return mail all the information concerning this plan. Even if you are now covered by Hospitalization Insurance, you owe it to yourself and loved ones to look into this new plan . . . because, excepting Workmen's Compensation, this policy pays you benefits regardless of any other insurance you may have . . . I know you will be interested in this policy once you hear some of its many new and startling features which make it, in our opinion, the BEST Hospitalization Plan yet given to the public. As an example, Friends, unlike other Hospitalization Plans, this policy pays benefits for hospital room and board for one day, one week, one month or a whole year. Government hospitals, which are usually free are excepted. No waiting 30 or 60 days, it covers you immediately for all accidents and all sickness not requiring surgery . . . sickness requiring surgery covered after policy has been in force six months . . . Benefits for 64 specific surgical operations . . . Benefits for loss of life by travel accident . . . for those who want it a Maternity Rider is available at a small additional charge . . . EXTRA BENEFITS SUCH AS CASH FOR BLOOD TRANSFUSIONS . . . RENTAL OF WHEEL CHAIR OR CRUTCHES . . . OXYGEN, AND AMBULANCE FEES. Now listen to this! The new Provider also includes without extra charge special benefits for the dreaded disease of Polio. No REDUCTION OF BENEFITS ON ACCOUNT OF AGE . . . Claims are paid quickly. Folks, don't delay . . . look into this New Provider Policy right now . . . Write your name and adress on a post-card and send it to Hospital Plan . . . that is Hospital Plan in care of Radio Station . . . . . No agents will call . . . all inquires will be handled by mail . . . free and without any obligation to you. Information costs you absolutely nothing . . . Write today to Hospital Plan, Radio Station . . . . . .

The Opinion of the Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15,828

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY,
Petitioner,

vs.

FEDERAL TRADE COMMISSION, *Respondent.*

Petition to Review Decision of the Federal Trade Commission

[May 16, 1958.]

A. ALVIS LAYNE, JR. (T. S. L. PERLMAN, KENNETH TEASDALE AND COBBS, ARMSTRONG, TEASDALE & ROOS were with him on the brief) for Petitioner.

E. K. ELKINS, Attorney, Federal Trade Commission (EARL W. KINTNER, General Counsel, JAMES E. CORKEY, Assistant General Counsel and EDWIN S. ROCKEFELLER, Attorney, Federal Trade Commission, were on the brief) for Respondent.

Before GARDNER, *Chief Judge*, and JOHNSEN, *Circuit Judge*, and DUNCAN, *District Judge*.

GARDNER, *Chief Judge*.

This matter is before us on petition to review an order of the Federal Trade Commission requiring petitioner to cease and desist from certain unfair and deceptive acts and practices in commerce in violation of the Federal Trade Commission Act as amended: 15 U.S.C. Section 41 et seq. The order was issued after hearing on a complaint charging that the petitioner had, in the course of its

interstate business of selling accident and health insurance, falsely advertised its insurance policies and thereby violated the Federal Trade Commission Act. Petitioner answered admitting the use of the advertisements alleged but denied that its advertising was false or misleading or that it had violated the act. It also affirmatively alleged that prior to the issuance of the complaint members of the Commission's staff had reviewed its advertising and found it unobjectionable. On the issues thus joined a hearing was had before an examiner who, after said hearing, in due course entered an initial decision which in effect held that petitioner's advertising representations had been unfair, misleading and deceptive in certain respects, but that the acts and practices complained of had been discontinued and there was no reasonable likelihood that they would be resumed, and on that ground entered a provisional order dismissing the complaint without prejudice. From that part of the provisional order dismissing the complaint counsel supporting the complaint appealed to the Commission. No appeal was taken by petitioner from that part of the provisional order determining that it had violated the act by its deceiving and unfair advertising practices, and in its answering brief before the Commission it declared that:

> "Respondent has not insisted upon its denials of jurisdiction or of violation • • •. It has filed no appeal from the Examiner's findings of jurisdiction or of violation; and if further assurance is needed, it is now prepared to concede it has violated the law and that the Commission has jurisdiction".

The examiner found the advertising of petitioner violative of the provisions of the Federal Trade Commission Act in the following particulars:

1. That is misrepresented the amounts paid as benefits for surgical operations;

2. That it misrepresented the extent of coverage for death resulting from travel accidents; and

3. That it misrepresented that, except for specific stated limitations, the policies provided indemnification for losses or expenses resulting from any or all sicknesses or accidents.

These specific findings were approved and adopted by the Commission and in addition it found that petitioner had misrepresented that its policies might be kept in force continuously at the option of the insured. The Commission found all representations charged in the complaint to have been false and misleading and also found, contrary to the finding of the trial examiner, that the deceptive practices had not been discontinued. It thereupon entered its order requiring petitioner to cease and desist from representing, directly or by implication:

> "1. That any such policy may be continued in effect by the insured upon payment of stipulated premiums, indefinitely or for any stated time, unless full disclosure of any other provision or condition of termination contained in the policy is made conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive.
>
> "2. That said policy provides for payment in full or in any specified amount or for payment up to any specified amount for any medical, surgical or hospital service, unless the policy provides that the actual cost to the insured for that service will be paid in all cases up to the amount represented, or unless full disclosure of the schedule of payments for which the policy provides is made conspicuously, prominently and in sufficiently close conjunction with said representation as will fully relieve it of all capacity to deceive.
>
> "3. That said policy provides for indemnification against losses due to sickness or accident, unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnifications actually

provided are set forth conspicuously, prominently, and in sufficiently close conjunction with said representations as will fully relieve it of all capacity to deceive.

"4. That said policy provides for a stipulated sum to be paid upon the accidental death of the insured unless full disclosure of the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and in sufficiently close conjunction with the representation as will fully relieve it of all capacity to deceive."

Petitioner is an insurance company organized under the laws of the State of Missouri but it does an extensive business in states other than that of Missouri and conducts what is referred to in the record as a mail order insurance business in states other than Missouri. In its mail order insurance business it contacts its prospective customers by sending advertising material to them by mail and by broadcasting its advertising material over the radio. The advertising matter here in question pertains to its hospitalization and surgical policy called the "Provider" or "New Provider" policy which provides indemnity for loss of life by accidental bodily injury, for hospitalization and surgery due to sickness or accident and, through the use of various riders, can be modified or enlarged to cover a variety of contingencies. The names of prospective customers were received by petitioner from its existing policyholders and from radio advertising over various radio stations. It was the practice of petitioner upon receipt of the name of a prospective customer to send a form letter, which was always accompanied by a brochure describing the policy, two application forms and a return envelope. At times other advertising materials describing benefits or containing favorable comments from policyholders were enclosed with these letters. If favorable replies were not received from the first letter within about ten days a second letter of similar import was sent out and

this practice was repeated from time to time. The practice contemplated that the customer would send an application and initial premium payment by mail. No medical examination was required. The statements contained in the applications were relied upon by petitioner. There was no material conflict in the evidence.

In its petition to review the decision of the Commission petitioner in effect charges error in the decision of the Commission in the following respects: (1) The Commission erred in refusing to consider its own trade practice rules and in excluding evidence of petitioner's compliance with the trade practice rules, and (2) The Commission erred in striking the examiner's findings that the practices complained of had been abandoned.

It is argued by petitioner that the so-called trade practice rules had the force and effect of law and that its advertising material had been examined and approved by certain advisory attorneys of the Commission as not violative of these trade practice rules. Whether they should be so construed would not seem to be here material because petitioner is not charged with a violation of these trade practice rules but is charged with a violation of the Federal Trade Commission Act. Section 45(a)(1) of that Act, so far as here pertinent, reads as follows:

> "Unfair methods of competition in commerce, and unfair or deceptive acts or practices in commerce, are declared unlawful."

Section 45(a)(6) of the same act provides that:

> "The Commission is empowered and directed to prevent persons, partnerships, or corporations . . . from using unfair methods of competition in commerce and unfair or deceptive acts or practices in commerce."

As has been observed the examiner found petitioner guilty of violation of the Federal Trade Commission Act

in several particulars, but the examiner in his provisional order found that petitioner had discontinued the practices. Counsel supporting the complaint appealed from that part of the order finding that petitioner had discontinued the unlawful practices. Petitoner, however, did not appeal from that part of the order which found it guilty of such practices but, on the other hand, specifically disclaimed that it was contesting the findings of the examiner in that regard. Having filed no cross-appeal to the Commission it in effect supported the order of the examiner as entered. In *Barnsdall Refining Corp.* v. *Cushman-Wilson Oil Co.*, 8 Cir., 97 F.2d 481, we announced the rule as follows:

> "The successful party, in the absence of a cross appeal, can not be heard to urge error in the trial of the action."

There was therefore not presented to the Commission the question of the sufficiency of the evidence to sustain the findings of the examiner on the issue of petitioner's unlawful practices. This is made clear in petitioner's answering brief on appeal to the Commission wherein it is declared that:

> "Respondent has not insisted upon its denials of jurisdiction or of violation * * * It has filed no appeal from the Examiner's findings of jurisdiction or of violation and if further assurance is needed, it is now prepared to concede it has violated the law and that the Commission has jurisdiction."

In this state of the record petitioner cannot now be heard to contend that the evidence is insufficient to sustain the findings of the examiner adopted by the Commission. *United States* v. *Tucker Truck Lines*, 344 U.S. 33; *Unemployment Comm'n.* v. *Aragon*, 329 U.S. 143. In *United States* v. *Tucker Truck Lines*, supra, the Supreme Court declared inter alia:

> "Simple fairness to those who are engaged in the tasks of administration, and to litigants, requires as

> a general rule that courts should not topple over administrative decisions unless the administrative body not only has erred but has erred against objection made at the time appropriate under its practice."

The governing rule is stated by the Supreme Court in *Unemployment Comm'n* v. *Aragon*, supra, as follows:

> "A reviewing court usurps the agency's function when it sets aside the administrative determination upon a ground not theretofore presented and deprives the Commission of an opportunity to consider the matter, make its ruling, and state the reasons for its action."

The admission of petitioner at the trial of the issues before the Commission that the examiner's findings of deception were correct certainly warranted the Commission in approving and adopting them.

It is next urged that the Commission erred in finding, contrary to the provisional order of the examiner, that the deceptive practices had not been discontinued. Petitioner has not abandoned its practice of sending through the mail its form letters and application forms. These were held to contain deceptive representations. The brochure was omitted from the letters and a miniature policy form was enclosed. The miniature policy was of necessity in small print and of very considerable length. The letters and other enclosures were much more easily read and it cannot be said that the miniature policy enclosed was read and relied upon, rather than the letters and enclosures. Apparently petitioner was not satisfied to rely solely upon the statements made in the policy as its advertising material; otherwise it would not have continued to enclose the form letters. It being established that the form letters were deceptive, there is no certainty that they would not be relied upon by the recipients. It is significant too that the form letters made no reference to

the fact that a miniature copy of the policy was enclosed. The fact that there was no evidence that anyone had in fact been deceived in relying on petitioner's advertisements was not conclusive. The test was whether such advertisements were likely to deceive. *Cleo Syrup Corporation* v. *Coca-Cola Co.*, 8 Cir., 139 F.2d 416. These deceptive form letters and applications might not have deceived shrewd, experienced businessmen but they were sent indiscriminately to names secured by petitioner from its policyholders, or by radio advertising. These doubtless included, or might have included from time to time, all classes and conditions, educated or uneducated, and the recipients were warranted in relying upon the statements contained in these letters and we cannot presume they suspected the honesty of those with whom they transacted business. *Federal Trade Commission* v. *Standard Education Society*, 302 U.S. 112; *United States* v. *Sylvanus*, 7 Cir., 192 F.2d 96. In *Federal Trade Commission* v. *Standard Education Society*, supra, the Supreme Court said:

> "Laws are made to protect the trusting as well as the suspicious."

And in *United States* v. *Sylvanus*, supra, the court said:

> "Under repeated decisions, the purchaser is entitled to rely upon the representations made. He need not distrust what is told him. * * * It goes without saying almost that it is extremely difficult for a layman to understand the terms and conditions of such policies as these, but whether the applicants did or did not read and understand the policies is beside the point."

In *Dorfman* v. *Federal Trade Commission*, 8 Cir., 144 F.2d 737, it was contended that the order to cease and desist entered by the Commission was too broad in that it required orders of purchasers to be clear and under

standable, both as to quantity of merchandise purchased and the price to be paid. Answering this contention we said, inter alia:

> "If to accomplish this purpose a blank order form is used which is not clear without an extension of the totals, then such extension is required. It is within the power of the Commission to require the preparation of orders for interstate sales which shall be clear not only to experts but which may also readily be understood by *'that vast multitude which includes the ignorant, the unthinking and the credulous.' Florence Mfg. Co.* v. *J. C. Dowd & Co.*, 2 Cir., 178 F. 73, 75." (Italics supplied)

These form letters in many particulars contained direct appeals to their recipients. For instance, the recipient was exhorted to "mail your application right now"; "Mail your application Now"; "apply now * * * Fill out and sign the enclosed enrollment form today"; "mail the enclosed application right now * * * Mail your application today"; and "Send in your application right now". As hereinbefore noted, these letters contained no reference to the enclosed miniature policy nor any suggestion that the provisions of the policy be read. We are of the view that the evidence warranted the finding and conclusion that petitioner had not discontinued its unfair and deceptive practices.

It is argued by petitioner that its course of conduct persuasively indicates that it has at all times been cooperative in its attempt to comply with and follow any directions or commands of the Commission and that the filing of the complaint was unnecessary and without warrant. Under the law it was the duty of the Commission to prevent the use of unfair methods of competition in commerce and unfair or deceptive acts or practices in commerce, and the only method provided by law for enforcement is by the issuance of an appropriate order to cease and desist. We cannot say that there was an abuse

of discretion in following the procedure specifically authorized by law.

We have considered all the other contentions urged by the petitioner but think they are not pertinent to the controlling issues and hence without merit. The cease and desist order appealed from is therefore affirmed and a decree of enforcement will be entered.

JOHNSEN, *Circuit Judge*, dissenting.

The Federal Trade Commission promulgated "Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance", 15 Fed. Reg. 955. It invited members of the industry to become signatories to those Rules, in indication of any such member's desire to secure cooperative achievement, both in its own business and in the field generally, of the purposes of the Act. It set up a Rules Administration Division, in facilitation of this endeavor, to enable any signatory, among other things, to submit its forms of advertising and solicitation for scrutiny and suggestion, with either expression or implication of sanction or approval, as being in conformity with the standards of the Rules and so presumptively non-violative of the Act. It allowed the Staff of its Rules Division to exercise the functions of advisorily engaging in such sanctions and approvals of forms of advertising and solicitation thus submitted. Then, in petitioner's case, it stepped in—without revocation of the Rules, without notice of repudiation of its Staff's actions, and without request on petitioner to cease further use of such materials—filed a complaint requiring petitioner to show cause why a cease and desist order should not be entered against it, and on hearing, with no challenge as to the good faith of the seeking or granting of such approval, entered a cease and desist order against petitioner, as a violator of the Act, in having made use of some of such Staff-sanctioned advertising and solicitation forms.

Beyond this, it preliminarily ruled as to the hearing had that evidence as to the facts referred to in the preceding paragraph could be "in no way relevant or material to any issue in the proceeding", so that petitioner was precluded from having such evidence considered, either on the merits of the question of deceptiveness in practical aspect, or as an element on the need for a cease and desist order in the circumstances of the particular situation.

It seems to me that this constituted fundamental lack of fair play in administration and processive arbitrariness in hearing. I do not believe that a use of advertising or solicitation forms, approved by the Commission's Staff, under trade practice rules promulgated by the Commission and under sanctioning procedures authorized by it in relation thereto, can constitute such "deceptive act or practice" as the Act contemplates should be made the subject of a cease and desist proceeding, and on which the Commission may presume to speak—until after there has been a removal of its administrative insulation.

That administrative insulation has, of course, now been removed in the present situation by the indications made in the rulings and results of this proceeding. But in effecting the deinsulation, the Commission should not, within the purpose and spirit of the statute, be allowed to pillory petitioner as a law violator, in the fists of its competitors and in the eyes of the public, for what was done, not as petitioner's act alone, but as an act of purported administrative insulation.

I would remand the case to the Commission, with leave to hold open the complaint, until it is seen whether further use is made by petitioner of the deinsulated material, and on that basis to enter a cease-and-desist or dismissal order.

A true copy.

Attest:

Clerk, U. S. Court of Appeals, Eighth Circuit.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15828

American Life and Accident Insurance Company,
Petitioner,

v.

Federal Trade Commission,
Respondent.

FINAL DECREE ENFORCING ORDER TO CEASE AND DESIST

American Life and Accident Insurance Company, a corporation, petitioner herein, having filed in this Court on June 27, 1957, a petition to review and set aside an order to cease and desist issued against it on April 19, 1957, by the Federal Trade Commission, respondent herein, in a proceeding before it entitled "IN THE MATTER OF AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY, a corporation, Docket No. 6238"; and a copy of said petition having been served upon respondent; and respondent having thereafter certified and filed herein, as required by the Federal Trade Commission Act, a transcript of the entire recordin said proceeding; and the matter having been heard by this Court on briefs and oral argument on March 5, 1958; and this Court having thereafter fully considered the cause and having rendered its decision on May 16, 1958, affirming said order:

NOW, THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the aforesaid petition to review be, andit hereby is, dismissed, that the aforesaid order to cease and desist, as heretofore affirmed, be, and it hereby is, enforced, and that petitioner be, and it hereby is, commanded to obey said order and to comply therewith; and

IT IS HEREBY FURTHER ORDERED, ADJUDGED AND DECREED that within sixty days from date of issuance of certified copy of this decree to the Federal Trade Commission the petitioner file with the Federal Trade Commission a report in writing, setting forth in detail the manner and form in which it has complied with said order to cease and desist.

Without prejudice to the right of the United States, as provided in Section 5(1) of the Federal Trade Commission Act, to prosecute suits to recover civil penalties for violation of the aforesaid order to cease and desist, hereby enforced, and without prejudice to the right of the Federal Trade Commission to institute and maintain contempt proceedings for violation of this decree, this Court retains jurisdiction of this cause to enter such further orders herein from time to time as may become necessary effectively to enforce compliance in every respect with this decree and to prevent evasion thereof.

June 13, 1958.

IN THE

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15828

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY,
Petitioner

v.

FEDERAL TRADE COMMISSION, *Respondent*

On Petition for Review of a Decision of the Federal Trade Commission

PETITION FOR REHEARING

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PRESS OF BYRON S. ADAMS, WASHINGTON, D. C.

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IN THE

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15828

AMERICAN LIFE AND ACCIDENT INSURANCE COMPANY,
Petitioner

v.

FEDERAL TRADE COMMISSION, *Respondent*

On Petition for Review of a Decision of the Federal Trade Commission

PETITION FOR REHEARING

American Life and Accident Insurance Company files this petition for rehearing to direct the attention of the Court to the following matters of fact and law which petitioner believes the Court overlooked and which petitioner believes are controlling.

PETITIONER DID NOT CONCEDE THAT IT VIOLATED THE LAW OR THAT THE COMMISSION HAD JURISDICTION

The Court's holding on the first assignment of error appears to rest in part upon the proposition that in the existing "state of the record petitioner cannot now be heard to contend that the evidence is insufficient to sustain the

findings of the examiner adopted by the Commission" (Slip Opinion, p. 7). The state of the record referred to is asserted to be that petitioner had "not presented to the Commission the question of the sufficiency of the evidence to sustain the findings of the examiner on the issue of petitioner's unlawful practices" (*ibid.* pp. 6-7) (1) because petitioner failed to cross-appeal to the Commission from the Examiner's order and (2) because petitioner's answering brief on appeal to the Commission constituted an admission that the Examiner's findings of deception and jurisdiction were correct. This overlooks several important matters of fact and law.

1. The Commission Finally Excluded Petitioner's Trade Practice Rule Evidence and Defense Prior to the Examiner's Order and Findings.

Before any testimony was taken in the proceeding, petitioner moved for dismissal on the ground that its prior compliance with the Trade Practice Rules barred the proceeding, or, in the alternative, to sever the issues of Trade Practice Rule compliance for a separate hearing prior to a hearing on the complaint (Tr. 31-43). This motion was certified to the Commission by the Examiner pursuant to § 3.15(c)(9) of the Commission's Rules of Procedure (Tr. 46). The Commission denied the motion (Tr. 48).

Thereafter, at the beginning of petitioner's presentation of evidence before the Examiner, petitioner applied for subpoenas duces tecum to obtain the records of the Commission as to petitioner's compliance with Trade Practice Rules (R. 95-99). The subpoena was granted but quashed on motion of Commission counsel, on the ground that evidence of compliance with Trade Practice Conference Rules was immaterial and irrelevant to any issue in the proceeding (R. 101). It was stipulated by the Commission counsel and petitioner that if an appeal were taken from the ruling of the Examiner, the Commission would sustain the ruling on the grounds stated in Docket No. 6276,

In the Matter of Postal Life and Casualty Insurance Company, (R. 108-112), decided a few days prior to the motion to quash the subpoena (R. 106).

At the same time petitioner sought by motion addressed to the Commission, pursuant to § 1.134 of the Commission's Rules of Practice, the evidence also relating to its Trade Practice Rule compliance sought through the subpoena duces tecum. This motion was denied by the Commission and petitioner was refused access to the evidence on the ground that such evidence would in any event be irrelevant and immaterial to any issue in the proceeding (R. 107).

These rulings of the Commission, although finally dispositive of the issues within the procedures of the Commission, were not then judicially reviewable because no final order had been entered. They could be judicially reviewed only after the entry of the final order to cease and desist. It would have been futile and unnecessary for petitioner to reargue the evidentiary question to the Commission, which had decided it. *Cf. Levers* v. *Anderson*, 326 U.S. 219; Administrative Procedure Act, §§ 10(c), 10(e) (5 U.S.C. 1009(e).[1] Petitioner raised the issue in this Court at its first opportunity.

We are confirmed in our view that the Court has overlooked the fact that the Commission ruled, both directly and on appeal from the Examiner, on the evidentiary question of trade practice rules by the Court's citation of and quotation from *United States* v. *Tucker Truck Line*, 344 U.S. 33, and *Unemployment Comm'n* v. *Aragon*, 329 U.S. 143 (Slip Opinion, p. 7). The passage quoted from *Unemployment Comm'n* v. *Aragon* refers only to errors "not theretofore presented" to the Commission, of which it is deprived "of an opportunity to consider the matter,

[1] "Any preliminary, procedural, or intermediate agency action or ruling not directly reviewable shall be subject to review upon the review of the final agency action * * * "

make its ruling and state the reasons for its action." Petitioner presented its ground repeatedly (Tr. 31-43; R. 89-95, 95-99), and the Commission had repeated opportunities, of which it availed itself, to consider the matter, make its ruling, and state its reasons (Tr. 48; R. 107, 108-112). Likewise *United States* v. *Tucker Truck Line* refers to absence of "objection made at the time appropriate under [the agency's practice]." Nothing in the record or in the Commission's Rules of Practice, then or now, suggests that it was procedurally inappropriate for petitioner to make its objections in the manner that it did.

2. The Court Has Misconstrued Petitioner's Statement Before the Commission.

The passage quoted by the Court (Slip Opinion, pp. 2, 7) from petitioner's answering brief on appeal before the Commission was inserted pursuant to a requirement of the Commission as a formal prerequisite to alleging the defense of abandonment. The concession was made for the limited purpose of permitting consideration of the issue raised by that defense, and was conditional upon the Commission's accepting that defense. It was not relied upon by the Commission, and should not be read, as a waiver of petitioner's contentions on other issues in the case, when the abandonment issue was held to be unavailable to petitioner.

After the Commission's preliminary rulings rejecting petitioner's evidence and defenses, petitioner's only remaining available defense was that based on the abandonment (discontinuance) of its allegedly deceptive practices. Such a defense is in effect an assertion that even if petitioner had violated the law, no order should be entered against it. The Examiner found in petitioner's favor on this issue. The Commission's counsel supporting the complaint appealed from this finding. The Commission had recently held, in accordance with a position frequently put forward by it, that the defense of abandonment could

not be successfully urged by a respondent who continued to contest the Commission's jurisdiction or to deny the unlawfulness of the respondent's acts. *National Casualty Co.*, Federal Trade Commission Docket No. 6311 (decided May 25, 1956), reversed on other grounds, 245 F. 2d 883 (C.A. 6), now pending on writ of certiorari, 355 U.S. 867. The Commission stated the requirements of waiver necessary to argue abandonment in *Massachusetts Boyding and Insurance Co.*, Federal Trade Commission Docket No. 6447 (decided November 7, 1956), as follows:

> "One of the circumstances which, to the Commission, seems significant is the respondent's insistence throughout this proceeding that the Commission is without jurisdiction over any of the respondent's activities. Another is the respondent's contention, which it has maintained with equal vigor, that none of its advertising statements or representations, including those referred to in the complaint, were in any respect false or misleading. Thus, the respondent is in the position of having agreed to comply with trade practice rules which it believes are without force and effect, and to refrain from the use of advertising representations which it believes it has a legal right to make. In these circumstances the Commission cannot find that the public interest would be served by a termination of this proceeding, and, accordingly, the respondent's motion must be denied."

In the brief on appeal from the Examiner's order in this case, counsel for the Commission stated (Tr. 452):

> "It would seem that the hearing examiner has dismissed the complaint indirectly for reasons which he could not use directly. There can be no question of estoppel of the Federal Trade Commission in this proceeding and therefore the point of whether respondent was or was not complying with the 1950 rules will not be belabored. The only question is whether the discontinuance of certain pieces of advertising, obviates the necessity for a cease and desist order. *The Commission has been afforded no basis for a conclusion*

that the practices will not be resumed in the future. Respondent has continually denied that the Federal Trade Commission has any jurisdiction to regulate its advertising. Respondent has also denied that any of its advertising is or ever was false, misleading and deceptive." (Emphasis added).

Petitioner accordingly made the statement quoted by the Court for the limited purpose of bringing before the Commission the abandonment issue. By it petitioner was saying to the Commission in effect, "If you hold in our favor on this issue, we will no longer deny that we have acted unlawfully or that you have jurisdiction," as one would offer to abandon claims or defenses in connection with an offer in compromise. When the Commission rejected the offer, petitioner's concession was rejected with it.

The Court has extended the effect of the offer or conditional concession to other issues as though it were unconditional. Such a treatment amounts to a requirement that a respondent before the Commission give up valid defenses, including defenses going to the Commission's jurisdiction, as a price for asserting another, not inconsistent, valid defense. This is analogous to requiring a defendant to waive his right to appeal as a condition precedent to presenting a defense and is therefore unlawful. *Green* v. *United States*, 355 U.S. 184, 193-194. The Court's interpretation gives petitioner's statement in this contested case an effect broader than is ordinarily given in the Commission to a respondent's consent to the entry of a consent cease and desist order.[2]

---

[2] § 3.25(b) of the Rules of Practice and Procedure, relating to consent orders, provides:

"The agreement shall also contain a waiver by the respondents of any right to challenge or contest the validity of the order entered in accordance with the agreement, and may contain a statement that the signing of said agreement is for settlement purposes only and *does not constitute an admission by respondents that they have violated the law as alleged in the complaint.*" (Emphasis added).

The Commission itself did not give so broad an interpretation to petitioner's alleged concession. The Commission's opinion analyzes the evidence and considers the question of the lawfulness of petitioner's acts without reliance upon or reference to petitioner's alleged concession (R. 51-54).

3. The Court Is Incorrect in Treating Petitioner's Failure to Appeal From the Adverse Portions of the Examiner's Findings as a Waiver of Its Contentions.

The Examiner directed the complaint to be dismissed; his order was therefore, favorable to petitioner. The Commission's Rules of Practice are silent as to consequences of failure to appeal from adverse portions of favorable order (Slip Opinion, p. 6). In the absence of an explicit contrary provision in the Rules of Practice, petitioner should have been entitled to the benefit of the usual rule that a favorable decision below may be defended upon appeal upon any valid ground. *Jaffke* v. *Dunham*, 352 U.S. 280. In view of the ordinary rule, it would be a violation of the Administrative Procedure Act (Section 3(a), 5 U.S.C. 1002 (a))[3] to require an appeal for the protection of petitioner's position in the absence of a published statement in the Commission's rules to that effect.

The Commission's requirement of waiving other defenses as a prerequisite to alleging abandonment put petitioner to the Hobson's choice of defending the Examiner's order on the Examiner's grounds or on the merits and on the Commission's earlier errors in excluding the trade practice evidence, but not on both. Under the Court's decision, if successful respondents before the Examiner in abandonment cases cross-appeal to the Commission on the merits or on jurisdictional grounds, the result will be

---

[3] "No person shall in any manner be required to resort to organization or procedure not so published."

automatic reversal of the Examiner's findings of abandonment. *National Casualty Co., supra; Massachusetts Bonding and Insurance Company, supra.*

4. Petitioner Had No Opportunity Before the Commission to Object to Some of the Commission's Findings.

The Commission, in its final decision, made findings reversing findings of the Examiner on the merits favorable to petitioner on the issues of renewability of the policies and certain other matters relating to the lawfulness of petitioner's practices (R. 51-54). Petitioner never had an opportunity before the Commission to object to these findings.

5. In No Event Could Petitioner Confer Jurisdiction on the Commission by Waiver.

The erroneous nature, as a matter of law, of the Court's treatment of petitioner's asserted concession is further illustrated with respect to the matter of jurisdiction of the Federal Trade Commission. The opinion of the Court apparently assumes that the petitioner clothed the Commission with jurisdiction by a statement made in petitioner's appeal brief to the Commission. The jurisdictional question could not be waived by petitioner either in the Commission or in this Court. Jurisdiction could not be conferred upon the Commission by consent. *United States* v. *Griffin*, 303 U.S. 226. Issues as to the Federal Trade Commission's jurisdiction in this field are presently pending in the Supreme Court. *Federal Trade Commission* v. *National Casualty Co.*, certiorari granted, 355 U.S. 867; *Federal Trade Commission* v. *The American Hospital and Life Insurance Company*, certiorari granted, 355 U.S. 867, as well as in this Court in No. 15743, *Travelers Health Ass'n* v. *Federal Trade Commission.*

CONCLUSION

For the reasons stated, it is respectfully submitted that the case should be reheard and the opinion and decision of the Court modified in accordance with the matters set forth herein.

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Attorneys for Petitioner

June 5, 1958

Certificate

I certify that this petition is submitted in good faith not for the purpose of delay, and that the matters of fact and law stated herein are believed by me to be meritorious.

A. Alvis Layne, Jr.

(Order Denying Petition of Petitioner for Rehearing.)

United States Courtof Appeals
for the
Eighth Circuit

No. 15828 - - - September Term, 1957.
Friday, June 13, 1958.

American Life and Accident Insurance Company,

Petitioner,

vs.

Federal Trade Commission.

Petition to Review Decision of The Federal Trade Commission.

Petition for rehearing filed by petitioner in this cause having been considered by this Court, It is now here Ordered that the same be, and it is hereby, denied.

June 13, 1958

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15828. September Term, 1957.

American Life and Accident Insurance Company,

Petitioner,

vs.

Federal Trade Commission.

Petition to Review Decision of the Federal Trade Commission

On consideration of the motion of petitioner for stay of judgment and decree of enforcement in this cause pending petition to the Supreme Court of the United States for writ of certiorari, it is now hereby Ordered by this Court that the time in which to file report of compliance with Order to cease and desist dated April 19, 1957, which report is now due sixty days after July 3, 1958, be and the same is hereby extended for a period of thirty days and if within said period of thirty days there is filed with the Federal Trade Commission a certificate of the Clerk of the Supreme Court of the United States that a petition for writ of certiorari and record have been filed, the extension hereby granted shall continue to the final disposition of the case by the Supreme Court.

August 6, 1958

SEAL

Attest:

Robert C. Tucker
Clerk, U.S. Court of Appeals

VOL.

II

RECORD

SEP 13 1958
JAMES R. BROWNING, Clerk

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15830

ADMINISTRATIVE REVIEW

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,
Petitioner,

v.

FEDERAL TRADE COMMISSION, *Respondent.*

Petition to Review Decision of the Federal Trade Commission

FILED
SEP 20 1957

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United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15830

ADMINISTRATIVE REVIEW

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,
Petitioner,

v.

FEDERAL TRADE COMMISSION, *Respondent.*

Petition to Review Decision of the Federal Trade Commission

RECORD

UNITED STATES OF AMERICA
BEFORE FEDERAL TRADE COMMISSION

DOCKET NO. 6239

In the Matter of

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,
a corporation

Complaint

Pursuant to the provisions of the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 to 1015, inclusive), and by virtue of the authority vested in it by said Act, the Federal Trade Commission, having reason to believe that Automobile Owners Safety Insurance Company, a corporation, hereinafter referred to as respondent, has violated the provisions of said Act, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues its complaint, stating its charges in that respect as follows:

PARAGRAPH ONE: Respondent, Automobile Owners Safety Insurance Company, is a corporation duly organized, existing and doing business under and by virtue of the laws of the State of Missouri, with its office and principal place of business located at 1319 Walnut Street in the City of Kansas City, Missouri.

PARAGRAPH TWO: Respondent is now, and for more than two years last past has been, engaged as an insurer in the business of insurance in commerce, as "commerce" is defined in the Federal Trade Commission Act, by entering into insurance contracts with insureds located in various States of the United States other than the State of Missouri, in which states the business of insurance is not regulated by State law to the extent of regulating the practices of respondent alleged in this complaint to be

illegal. Respondent maintains, and at all times mentioned herein has maintained, a substantial course of trade in said insurance policies in commerce between and among the several States of the United States.

(3)

Respondent during the two years last past has issued a variety of policies providing indemnification for loss resulting from accidental injury and sickness, including Form No. 1-29-53, Form No. F-8-10-53 and Form No. 1-10-53.

PARAGRAPH THREE: Respondent is licensed, as provided by State law, to engage in the business of insurance, as heretofore generally described, in the State of Missouri. Respondent is not now, and during approximately two years last past has not been, licensed as provided by the respective State laws to engage in the business of insurance in any State of the United States other than the State of Missouri.

Respondent solicits business by mail in the various States of the United States in addition to the State of Missouri. As a result thereof it has entered into insurance contracts with insureds located in many States in which it is not licensed to do business. Respondent's business practices are not regulated by any of those states as it is not subject to the jurisdiction of such states.

PARAGRAPH FOUR: In the course and conduct of its aforesaid business, respondent, during approximately two years last past, disseminated and caused to be disseminated in the form of circulars and other printed and written matter, false, misleading and deceptive advertisements concerning the terms and provisions of its contracts of insurance. These advertisements were disseminated by the United States mails, or through the licensed

(4)

agents of respondent, in commerce between and among the various States of the United States. The purpose

and effect of these advertisements was, and is, to induce members of the public to become insured by the respondent under the terms and provisions of the policies advertised.

PARAGRAPH FIVE: In the course and conduct of its said business in said commerce, as aforesaid, the respondent has disseminated, among others of similar import and meaning, not herein set out, advertisements relating to its said policies containing statements hereinafter set forth.

1. "* * * automobile accidents happen every day. If such a misfortune occurs and you are injured in an automobile accident, you can have an income of $100.00 a month for life, while you are at home under medical care or hospitalized. Our policy insures you while driving or riding in any automobile, bus, or truck, and provides these benefits:

"1. *$100.00* a month beginning the first day you are injured. The policy provides that if you have an automobile accident and you are confined at home or in the hospital under medical care, you will be paid at the rate of $100.00 a month from the first day of injury even for life."

2. *Hospitalization*—$50.00 a week direct to you for 52 weeks if you are in the hospital for any sickness or any accident."

"$50.00 a week if you have any sickness or accident that sends you to a hospital, even for one day. This $50.00 is sent to you every week for as long as 52 weeks—up to $2600.00."

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PARAGRAPH SIX: Through the use of said statements and representations, and others of similar import and meaning not specifically set out herein, the respondent represents, and has represented, directly or by implication, with respect to said policies of insurance as follows:

(1) That any policyholder who is injured in an automobile accident will be indemnified in the amount of $100 a month from the first day of injury for life, the only condition being that the policyholder is confined at home or in a hospital under medical care.

(2) That the indemnification contained in said insurance policies provide cash benefits for a period of 52 weeks to the insured if hospitalized from any sickness or any accident.

PARAGRAPH SEVEN: The aforesaid statements and representations are false, misleading and deceptive. In truth and in fact:

(1) The indemnification providing the monthly payment described above is not payable for injuries sustained in an automobile accident resulting in confinement at home or in hospital under medical care. On the contrary, the said policies provide that the bodily injuries must be sustained while the insured is driving or riding within an automobile, bus or truck and such bodily injuries are caused solely by reason of an automobile, truck or bus accident, and that such monthly payments are then only payable if such injury shall, immediately after such accident, wholly and continuously disable and prevent the insured from performing any and every duty pertaining to any business or occupation and as a result thereof the insured is thereby necessarily confined within doors and requires regular visits therein by a legally licensed medical or osteopathic physician or surgeon; and further, that if the insured is disabled for more than 30 days, he or his representative shall furnish respondent company every 30 days with a report in writing from his attending physician or surgeon, fully stating the condition of the insured and the probable duration of the disability.

(2) The indemnification contained in said insurance policies do not provide cash benefits to the insured for a period of 52 weeks if hospitalized from any sickness or

any accident contracted or suffered by the insured. On the contrary, if the insured sustains no bodily injury from the accident suffered or the sickness is traceable to a

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condition existing prior to or within fifteen days after the date of the policy the insured is excluded by the terms of the policy from receiving the cash benefits for hospitalization.

The said insurance policies, by the terms thereof, exclude any hospitalization loss by the insured sustained outside the United States or Canada; losses resulting from use of narcotics or intoxicants. No hospitalization benefit is given the insured for losses resulting from syphilis, venereal disease, insanity, nervous or mental disorders.

The hospital benefit is not payable to the insured for tuberculosis, cancer, diabetes, any heart or circulatory disease or disturbance, hernia of any type, sickness or disease resulting in a surgical operation, sickness or disease of or involving organs which are peculiar to women if hospital confinement begins before the policy has been in force for more than six months; or at any time if the cause of such sicknesses are traceable to a condition existing before the effective date of the policy.

PARAGRAPH EIGHT: The use by the respondent of the aforesaid false and misleading statements and representations with respect to the terms and conditions of its said policies and its failure to reveal the limitations of said coverage found in said policies have had, and now have, the tendency and capacity to mislead and deceive and have misled and deceived a substantial portion of the purchasing public into the erroneous and mistaken belief that the aforesaid statements and representations were and are true and to induce said portion of the purchasing public to purchase insurance coverage from the respondent because of said erroneous and mistaken belief.

PARAGRAPH NINE: The aforesaid acts and practices of respondent, as herein alleged, are all to the prejudice and injury of the public and constitute unfair and deceptive acts and practices in commerce within the intent and meaning of the Federal Trade Commission Act.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this 14th day of October, A. D., 1954, issues its complaint against said respondent.

NOTICE

* * * * * * * * * * *

(7)

Failure to file answer within the time above provided and failure to appear at the time and place fixed for hearing shall be deemed to authorize the Commission and Hearing Examiner J. Earl Cox, without further notice, to find the facts to be as alleged herein and to issue the following order in this proceeding:

IT IS ORDERED that respondent, Automobile Owners Safety Insurance Company, a corporation, and its officers, agents, representatives and employees, di-

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rectly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from:

(A) Representing, directly or by implication:

(1) That said policy provides for a specified income for life if the insured is injured in an automobile accident, as long as he is confined at home or in a hospital under medical care, when the policy does not

provide for the payment of the specified income for life in all such cases.

(2) That said policy provides for indemnification to insured in cases of sickness or accident generally or in any or all cases of sickness or accident, when such is not the fact.

(B) Misrepresenting in any other manner or by any other means the terms or provisions of said insurance policies.

The inclusion of such order to cease and desist in this complaint will be without effect in the event you show cause, on or before the 13th day of December, A. D., 1954, why such order should not issue.

IN WITNESS WHEREOF, the Federal Trade Commission has caused this, its complaint, to be signed by its Secretary, and its official seal to be hereto affixed, at Washington, D. C., this 14th day of October, 1954.

By the Commission.

SEAL

ROBERT M. PARRISH,
Secretary.

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[Caption omitted]

Answer and Motions

Pursuant to the requirements of Rule VIII of the Rules of Practice of the Federal Trade Commission, respondent makes the following answer and alternative motions to the complaint in this proceeding:

1. Respondent admits the allegations of Paragraph One of the complaint.

2. Respondent admits that during approximately the two years last past it has issued policies of insurance providing indemnification for loss resulting from accidental injury and sickness and that for a part of this period respondent issued Form No. 1-29-53; Form No. F-8-10-53; and Form No. 1-10-53. Except as herein specifically admitted, respondent denies each and every allegation of Paragraph Two of the complaint.

3. As to Paragraph Three of the complaint, respondent admits that it is licensed to engage in the business of insurance by the State of Missouri, as provided by the laws of that State. Respondent is not licensed by any State other than the State of Missouri. All aspects of respond-

ent's business, including *inter alia*, financial requirements, policy forms, claims practices, advertising practices, are regulated by and subject to the regulation of the laws of the State of Missouri. Respondent admits that it advertises its policies by mail, some of which is sent to various States of the United States in addition to the State of Missouri. Respondent has issued in the State of Missouri insurance policies to persons located in States of the United States other than the State of Missouri. Respondent admits that it is not subject to the jurisdiction of any State other than the State of Missouri because it is not conducting an insurance business in any State other than the State of Missouri. Except as herein specifically admitted, respondent denies each and every allegation of Paragraph Three of the complaint.

4. Respondent admits that during approximately two years last past, it has disseminated through the United States mails advertisements of its policies. Except as to the extent herein specifically admitted, respondent denies each and every allegation of Paragraph Four of the complaint.

5. Respondent denies each and every allegation of Paragraph Five of the complaint except that it admits that the quotation of a purported advertisement is a partial quotation taken out of context from a letter, the use of which had been discontinued by respondent prior to the filing of the complaint in this proceeding.

6. Respondent denies each and every allegation of Paragraph Six of the complaint.

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7. Respondent denies each and every allegation of Paragraph Seven of the complaint.

8. Respondent denies each and every allegation of Paragraph Eight of the complaint.

9. Respondent denies each and every allegation of Paragraph Nine of the complaint.

10. Respondent states and alleges that:

(a) The business of respondent does not constitute "commerce" as that term is defined by the Federal Trade Commission Act and respondent is not engaged in commerce.

(b) The business of respondent is "regulated by state law" as that term is used in Public Law 15, 79th Congress (15 U.S.C. § 1011 et seq.), and hence the Federal Trade Commission Act is not applicable to respondent or the business of respondent.

11. Respondent further states that:

Upon the organization of respondent within two years last past, respondent through its representative indicated to the Federal Trade Commission its desire and purpose to adhere to the Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance promulgated February 3, 1950. During this period and prior to the resolution of the Commission dated De-

cember 15, 1953, instituting a general investigation of advertising practices of the accident and health insurance industry, respondent made available to the Commission

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and members of the staff its policies and advertising materials. At no time, until the filing of the complaint in this proceeding, did the Commission or any of the members of its staff suggest or intimate that respondent's advertising materials were subject to any criticism or question. Representatives of respondent, moreover, requested that any criticism or objection be communicated to respondent.

WHEREFORE, respondent respectfully requests and moves:

1. That the complaint be dismissed on the ground that the Federal Trade Commission Act has no application to the business of respondent.

2. In the alternative, that the complaint be dismissed and the matter be referred to the Bureau of Consultation of the Commission for handling and disposition under the cooperative procedures of that Bureau.

s/ A. ALVIS LAYNE, JR.
A. Alvis Layne, Jr.
Pennsylvania Building
Washington 4, D. C.

s/ WENDELL BERGE
Wendell Berge
Ring Building
Washington 6, D. C.

Attorneys for Respondent

Filed December 3, 1954

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[Caption omitted]

Initial Decision

By J. Earl Cox, Hearing Examiner.

F. C. Mayer and P. R. Melaugton for the Commission;

A. Alvis Layne and T. S. L. Perlman, Washington, D. C., for the Respondent.

The respondent in this proceeding is charged with violating the Federal Trade Commission Act, as that Act is applicable to the business of insurance under the provisions of Public Law 15, 79th Congress (Title 15, U. S. Code, Sections 1011 to 1015), by disseminating false and misleading advertising relating to accident and health insurance policies which it has sold in commerce. By answer respondent denies that it has violated the law as charged, specifically alleging that it is not engaged in commerce as that term is defined by the Federal Trade Commission Act; that its business is regulated by state law and hence the Federal Trade Commission Act is not applicable to respondent or its business; that it has expressed its "desire and purpose to adhere to the Trade Practice Rules Relating to the Advertising and Sales Promotion of Mail Order Insurance promulgated February 3, 1950", has "made available to the Commission and members of the staff its policies and advertising materials and that neither the Commission nor any member of its staff suggested that any of its advertising material was subject to any criticism or question".

With the answer a motion was filed requesting that the complaint be dismissed on the ground that the Federal Trade Commission Act has no application to the business of respondent, or, in the alternative, that the complaint be dismissed and the matter referred to the Bureau of

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Consultation of the Commission for handling and disposition under the cooperative procedures of that Bureau.

This motion was denied by the Hearing Examiner, the first part because it raised a question of jurisdiction which could best be resolved after all the relevant evidence in support of the complaint had been presented; the second part because it was not within his authority in the matter. No appeal was taken to the Commission from the rulings of the Hearing Examiner.

At the close of the taking of evidence in support of the complaint respondent again presented a motion to dismiss the proceeding, based on two grounds: (1) that the evidence failed to establish facts sufficient to constitute jurisdiction, and (2) that the evidence did not show violation of the Federal Trade Commission Act. This motion was denied by the Hearing Examiner on September 9, 1955, by an order which stated that the Federal Trade Commission does have jurisdiction in the matter and that a *prima facie* case had been established. Thereafter evidence was presented in opposition to the allegations of violation of law set forth in the complaint. Proposed findings of fact and conclusions of law have been submitted. Upon the basis of the entire record, the following findings and conclusions are made.

1. Respondent, Automobile Owners Safety Insurance Company, is a corporation organized in January, 1953, doing business under the laws of the State of Missouri, with its office and principal place of business at 1319 Walnut Street, Kansas City, Missouri. It sells accident and health insurance policies in commerce to purchasers and insureds located in every state except Virginia. Its business has been and is substantial.

2. Three of respondent's policies are in evidence in this proceeding. One policy, the Automobile Owner's Accident and Hospital Policy, identified as Form 1-29-53, provides coverage for death and disabilities from automobile accidents. Between February, 1953 and about the middle of 1954 this policy was sold to 38,882 policyholders residing outside the State of Missouri, in every

state except Virginia. Another policy, designated Automobile Owner's Accident and Family Hospital Policy, Form F-8-10-53, provides indemnity for loss of life or time due to certain automobile accidents and losses due to hospital expenses resulting from accidents and sickness. It was issued between August 10, 1953, and July 19, 1954 to 63,879 persons living outside Missouri in every state except Virginia. A third policy, Form No. 1-10-53, similar to the F-8-10-53 policy, was sold for a short period of time, but the complaint contains no charges which relate to it or its advertising.

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Method of Solicitation and Sale:

3. Respondent employed an affiliated company known as Automobile Owners Association, Inc., hereinafter referred to as the Association, as its exclusive agent for the solicitation of business. No advertising by newspaper, magazine, radio, television or other medium was used. Solicitation was entirely by mail. All advertising material was prepared by an advertising agency and approved by respondent, but the printing and mailing was by a Chicago mailing house which also furnished the lists of persons to whom the literature was sent by third-class mail. Different form letters and application blanks were used in soliciting the sale of the two policies involved in this proceeding.

4. With respect to policy 1-29-53, two regular mailings were made, one in February and March of 1953, and one in February and March of 1954. There was also a special experimental mailing of approximately 100,000 letters in February or March, 1954. With respect to policy F-8-10-53, mailings were made at intervals throughout the period during which that policy was sold. Each solicitation letter, except the special mailing, invited the recipient to join the Association provided he had not had an automobile accident in the preceding twelve months,

and stated that as a member he would be entitled to apply through the Association for the particular policy mentioned in the letter. Each prospective purchaser also received a return envelope and an application form which he was asked to fill out and return with the appropriate initial premium. In the special experimental mailing the invitation to become a member of the Association was omitted.

5. Completed applications with initial premium remittances, when received, were transmitted by the Association to respondent's underwriting department, which passed upon the applications and issued the policies. Policy 1-29-53 was issued if the applicant for that policy had had no automobile accident within the preceding twelve months. Policy F-8-10-53 was issued without further question if the application for that policy showed no medical consultations within the preceding three years; if such consultations were shown, then approval was based upon an estimate of the risk after further inquiry. Upon issuance, policies were mailed to insureds with covering letters and premium receipts.

The Charges:

6. The complaint contains only two charges. The *first charge* is that the respondent has represented in its advertising literature:

> that any policy-holder who is injured in an automobile accident will be indemnified in the amount of $100 a month from the first day of injury for life,

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> the only condition being that the policy-holder is confined at home or in a hospital under medical care.

This is alleged to be false, misleading and deceptive, because in truth and in fact the indemnification providing the monthly payment referred to in respondent's adver-

tising is not payable for all injuries sustained in an automobile accident resulting in confinement at home or in hospital under medical care. On the contrary, respondent's policies provide that the bodily injuries must be sustained while the insured is driving or riding within an automobile, bus or truck, and such bodily injuries must have been caused solely by reason of an automobile, truck or bus accident, and that such monthly payments are then only payable if such injury shall, immediately after such accident, wholly and continuously disable and prevent the insured from performing any and every duty pertaining to any business or occupation and as a result thereof the insured is thereby necessarily confined within doors and requires regular visits therein by a legally licensed medical or osteopathic physician or surgeon; and further, that if the insured is disabled for more than thirty days, he or his representative shall furnish respondent company every thirty days with a report in writing from his attending physician or surgeon, fully stating the condition of the insured and the probable duration of the disability.

7. The advertising relied upon to support this charge is set forth in the complaint as follows:

> "* * * automobile accidents happen every day. If such a misfortune occurs and you are injured in an automobile accident, you can have an income of $100.00 a month for life; while you are at home under medical care or hospitalized. Our policy insures you while driving or riding in any automobile, bus, or truck, and provides these benefits:
>
> "1. *$100.00* a month beginning the first day you are injured. The policy provides that if you have an automobile accident and you are confined at home or in the hospital under medical care, you will be paid at the rate of $100.00 a month from the first day of injury even for life."

8. These statements are made in form letters soliciting purchase of respondent's Automobile Owners Accident and Hospital Policy, form 1-29-53, which offers insurance "against loss from accidental bodily injury sustained while driving or riding within any automobile, truck or bus for business or pleasure during the term of this policy, provided such bodily injuries are caused solely by reason of an automobile, truck or bus accident", and provides monthly accident benefits of $100 for life

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"If 'Such Injury' as described in the Insuring Clause, and not hereinafter excepted or for which indemnity is provided in Part Two shall immediately after accident wholly and continuously disable and prevent the Insured from performing any and every duty pertaining to any business or occupation, and as the result thereof is thereby necessarily confined within doors and requires regular visits therein by a legally licensed medical or osteopathic physician or surgeon, the Company will pay for any one accident an indemnity for one day or more at the rate of One Hundred Dollars ($100.00) per month even for life, so long as such disability and confinement continues."

Policy 1-29-53 provides limitations and conditions as follows:

"This insurance does not cover any disability or loss (1) unless sustained in the Continental limits of the United States or Dominion of Canada, nor (2) resulting from the Insured being under the influence of intoxicants or narcotics, nor (3) while participating in or attempting to commit a felony, or to which a contributing cause was the Insured's being engaged in an illegal occupation, nor (4) resulting from Military or Naval Service.

"If the Insured is disabled more than thirty (30) days, he or his representative shall furnish the Com-

pany every thirty (30) days with a report in writing from his attending physician or surgeon, fully stating the condition of the Insured and the probable duration of the disability."

9. The advertising fails to disclose clearly (1) that an automobile, truck or bus accident must have been the sole cause of the injury; (2) that the injury must have resulted in immediate disability; (3) that the injury must have wholly and continuously prevented the insured from performing any and every duty of any business or occupation; (4) that the injury must have required regular visits by a licensed physician; (5) that a physician's report in writing must have been furnished every thirty days; (6) that injury must not have resulted from the insured being under the influence of intoxicants or narcotics nor while the insured was engaged in an illegal occupation or while participating in or attempting to commit a felony; and (7) that the injury must not have resulted from military or naval service.

10. The respondent contends that disclosure of these limitations in its advertising material is not required, since many of them, (1) through (5) in particular, have no effect on the payment of claims under the policy because the respondent interprets its policies liberally to the benefit of its policy-holders, the Missouri State Department of Insurance

discourages or forbids the interjection of technical defenses to obviate payment of claims, and ruling case law makes the limitations innocuous and ineffective. Respondent further contends that if the policy-holders receive the benefits that the Commission alleges respondent advertised, then any apparent provisions of the policy to the contrary are immaterial.

11. The issue, however, is whether respondent's policies provide the benefits advertised rather than whether, by

liberally interpreting policy provisions, respondent pays benefits which might not be collectible under a stricter interpretation of those provisions. The insured has a right to expect policy provisions, unequivocally and clearly, to provide the benefits advertised, without need of an elastic interpretation. Under Commission decisions the insured has a right to know, not only the affirmative provisions, but the negative ones as well. In the *American Hospital and Life Insurance Company* case, Docket 6237, the Commission ordered respondent to cease and desist from representing that its policy provides for indemnification against losses due to sickness or accident "unless a statement of all the conditions, exceptions, restrictions and limitations affecting the indemnification actually provided is set forth conspicuously, prominently, and, in sufficiently close conjunction with said representations as will fully relieve it of all capacity to deceive." A like provision is contained in the Commission's order in the *National Casualty Company* case, Docket 6311. Respondent's advertising does not so disclose all the conditions and limitations affecting the payment of the benefits provided by its policies, and therefore it is unfair, misleading and deceptive.

12. The *second charge* is that respondent has represented

> that the indemnification contained in respondent's insurance policies provide cash benefits for a period of 52 weeks to the insured if hospitalized from any sickness or any accident.

This representation is alleged to be false, misleading and deceptive because in truth and in fact

> "The indemnification contained in said insurance policies do not provide cash benefits to the insured for a period of 52 weeks if hospitalized from any sickness or any accident contracted or suffered by the

insured. On the contrary, if the insured sustains no bodily injury from the accident suffered or the sickness is traceable to a condition existing prior to or within fifteen days after the date of the policy the insured is excluded by the terms of the policy from receiving the cash benefits for hospitalization.

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"The said insurance policies, by the terms thereof, exclude any hospitalization loss by the insured sustained outside the United States or Canada; [and] losses resulting from use of narcotics or intoxicants. No hospitalization benefit is given the insured for losses resulting from syphilis, venereal disease, insanity, nervous or mental disorders.

"The hospital benefit is not payable to the insured for tuberculosis, cancer, diabetes, any heart or circulatory disease or disturbance, hernia of any type, sickness or disease resulting in a surgical operation, sickness or disease of or involving organs which are peculiar to women if hospital confinement begins before the policy has been in force for more than six months; or at any time if the cause of such sicknesses are traceable to a condition existing before the effective date of the policy."

13. This charge relates to policy F-8-10-53 and the advertising upon which it is based is set forth in the complaint as follows:

"*Hospitalization*—$50.00 a week direct to you for 52 weeks if you are in the hospital for any sickness or any accident."

"$50.00 a week if you have any sickness or accident that sends you to a hospital, even for one day. This $50.00 is sent to you every week for as long as 52 weeks—up to $2600.00."

In addition to the foregoing statements taken from respondent's F-8-10-53 solicitation letter, there appears on the application form which accompanied every such letter, the following:

> "BENEFITS START FROM THE FIRST DAY OF INJURY—and common and rare disease benefits start when sickness originates after the policy has been in force for 15 days. Serious diseases, such as cancer, tuberculosis, heart disease, disease involving female organs, and sickness resulting in serious operations are also fully covered after this policy is in force for 6 months. Suicide, insanity and venereal diseases are understandingly excluded."

14. Policy exclusions and limitations are as follows:

a. No payment shall be made for hospital indemnity provided herein unless actually necessary and recommended by a legally licensed medical or osteopathic physician or surgeon, other than the Insured.

b. This policy does not cover any disability or loss (1) unless sustained in the United States or Canada, nor (2) resulting from the Insured being under the influence of intoxicants or narcotics, nor (3) resulting from syphilis or venereal disease, nor (4) resulting from insanity or any attempt at suicide, nor (5) while participating in or attempting to commit a felony; or to which a contributing cause was the Insured's being engaged in an illegal occupation, nor (6) resulting from Military or Naval Service. The pro rata unearned premium for any period not covered while in Military or Naval Service will be returned.

c. This policy does not cover hospitalization for nervous or mental disorders, rest cures or alcoholism.

d. Tuberculosis, cancer, diabetes, any heart or circulatory disease or disturbance, hernia of any type, sickness or disease resulting in a surgical operation, sickness or disease of or involving organs which are peculiar to women, shall be covered only if hospital confinement begins after this policy has been in force for six months or more from the date hereof.

15. Not all of these exclusions, conditions and limitations are set forth conspicuously and prominently in respondent's advertising, as is required under the Commission's orders in the two similar cases referred to in Paragraph 11, above. To that extent, therefore, respondent's advertising of its F-8-10-53 policy has been unfair and deceptive. Some of the exclusions which were not mentioned in respondent's advertising were of seemingly minor importance; some were readable into the advertising by easy inference; still others might be considered to be within the realm of common knowledge; there were some which, during the time the policy was on sale, never arose in actual practice as a basis for denial of a claim. The record discloses no evidence of actual deception. However, on precedent it must be found that potential deception existed.

Jurisdiction:

16. Throughout this proceeding respondent has maintained that the Federal Trade Commission is without jurisdiction herein. That issue was ruled upon, at the close of the case-in-chief in support of the complaint, in an order that is part of the record in this proceeding and sets forth the conclusions then reached and the reasons therefor. No facts have arisen to justify a change in those conclusions, and the Hearing Examiner has, since that time, reached the same conclusions under similar circumstances in the matter of *American Life and Accident Insurance Company*, Docket 6238, and has set forth the reasons therefor in the Initial Decision therein. The

discussion need not be repeated here. The conclusion is that the Federal Trade Commission does have jurisdiction in this proceeding.

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Abandonment:

17. Within a month after the respondent corporation was organized, the Commission promulgated its Trade Practice Rules for the Advertising and Sales Promotion of Mail Order Insurance. These Rules remained in effect until they were revoked, on August 23, 1956, two and one-half months after the close of the taking of testimony and reception of evidence in this proceeding. During the entire period involved in this case, the respondent was under obligation to abide by and follow those Rules. In its first attempt to have its advertising conform to the prescribed requirements, respondent informed the Commission's Bureau of Industry Cooperation, now the Bureau of Consultation, of the content of the advertising then being used, which was identical with certain advertising material of Safety Drivers Insurance Company, a predecessor corporation, which had previously been submitted and revised to conform with recommendations made by the Bureau staff. Members of the staff of the Commission's Bureau informed respondent's representative that they had no complaint or suggestions of change regarding this advertising. Shortly thereafter the Commission instituted a general investigation of accident and health insurance advertising practices. At that time inquiry was made of the Commission as to whether the Trade Practice Rules would be continued in effect and if respondent would be afforded opportunity to correct advertising practices that the Commission might deem improper. No response to that inquiry was received from the Commission, and the first notice respondent received that its advertising was questioned was when the complaint was issued in this proceeding, on October 14, 1954.

18. Approximately three months before that date respondent had discontinued sale of the two policies involved in this proceeding. The last sale of policy 1-29-53 had been made about the middle of 1954; the last sale of policy F-8-10-53 occurred July 19, 1954. With the discontinuance of the sale of these policies, the solicitation letters and application forms referring thereto were also discontinued. Thus all the advertising complained of had been discontinued voluntarily prior to the issuance of the complaint.

Public Interest:

19. In the complaint the Commission stated that a proceeding by it in respect to the charges therein set forth would be in the public interest. There is nothing in the record to indicate what facts were before the Commission at that time, but now the hearings have been terminated and all the facts relative to the issues presumably have been presented. Those facts show that insofar as the respondent has failed to comply with the requirements of the Federal Trade Commission Act, it has been by acts

of omission rather than of commission; that respondent, over its entire period of existence, has tried consistently to cooperate with the Commission by submitting its advertising material and making changes therein to meet suggestions of the Commission's staff; that a continuation of such cooperative efforts may reasonably be expected; that the acts and practices complained of were discontinued before issuance of the complaint; that it is reasonable to asume that they will not be resumed in the future; and that all that could be accomplished by issuing a cease-and-desist order has been accomplished. There is no evidence that anyone has ever been deceived or misled by respondent's advertising. Under these circumstances, and in view of the fact that fundamentally the Commission's functions are prophylactic rather than punitive, it

appears that reliance upon the effectiveness of cooperation between the Commission and the respondent, and the dismissal of this proceeding without prejudice, would fully serve the public interest. Accordingly,

It Is Ordered that the complaint herein be, and the same hereby is, dismissed without prejudice to the right of the Commission to take such further action as it may deem appropriate.

/s/ J. Earl Cox
J. Earl Cox
Hearing Examiner.

October 4, 1956.

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[Caption omitted]

Findings As to the Facts, Conclusions and Order

Pursuant to the provisions of the Federal Trade Commission Act, the Federal Trade Commission, on October 14, 1954, issued and subsequently served upon respondent, Automobile Owners Safety Insurance Company, a corporation, its complaint, charging said respondent with the use of unfair and deceptive acts and practices in commerce in the sale of health and accident insurance policies, in violation of the provisions of the Federal Trade Commission Act.

Thereafter, respondent filed its answer and, in conjunction therewith, a motion requesting dismissal on the ground that the Federal Trade Commission Act has no application to the business of respondent, or, in the alternative, that the complaint be dismissed and the matter referred to the Bureau of Consultation of the Commission for handling and disposition under the cooperative procedures of the Bureau. This motion was denied by the hearing examiner duly designated in the complaint, the first part for the reason that the question of jurisdic-

tion could be resolved satisfactorily only after the submission of evidence, and the second part for the reason that it was not within the examiner's authority.

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Hearings were conducted in due course. At the close of the taking of evidence in support of the complaint, respondent again moved to dismiss the proceeding on the grounds: (1) that the evidence failed to establish facts sufficient to constitute jurisdiction, and (2) that the evidence did not show violation of the Federal Trade Commission Act. This motion was denied by the hearing examiner on September 9, 1955, by an order which stated that the Federal Trade Commission does have jurisdiction in the matter and that a *prima facie* case had been established. Subsequently, evidence was presented in opposition to the allegations of the complaint. The hearing examiner filed his initial decision on October 4, 1956, in which it was held that, in the circumstances shown, a dismissal of the proceeding would fully serve the public interest and in which it was ordered that the complaint be dismissed without prejudice to the right of the Commission to take such further action as it may deem appropriate.

Within the time permitted by the Commission's Rules of Practice, counsel in support of the complaint filed an appeal from said initial decision, and, the Commission, after considering said appeal, respondent's brief in opposition thereto, and the entire record herein, rendered its decision granting the appeal and vacating and setting aside the initial decision.

Thereafter, this matter came on for final consideration by the Commission, and the Commission, being now fully advised in the premises, makes the following findings as to the facts, conclusions drawn therefrom, and order, which, together with the aforesaid decision on the appeal, shall be in lieu of the initial decision of the hearing examiner.

FINDINGS AS TO THE FACTS

1. Respondent, Automobile Owners Safety Insurance Company, is a corporation, duly organized, existing and doing business under and by virtue of the laws of the State of Missouri, with its principal place of business located at 1319 Walnut Street in the City of Kansas City, State of Missouri. Respondent has been engaged in the business of health and accident insurance. It is licensed to engage in the business of insurance by the State of Missouri, but is not licensed by any state other than the State of Missouri.

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2. Respondent has been maintaining a substantial course of trade in commerce, as that term is defined in the Federal Trade Commission Act, in health and accident insurance, issuing policies to purchasers thereof located in every state except the State of Virginia. Three of its policies are in evidence in this proceeding. One policy, the Automobile Owners Accident and Hospital Policy, identified as Form 1-29-53, provides coverage for death and disabilities from automobile accidents. Between February, 1953, and about the middle of 1954, this policy was sold to 38,882 policyholders residing outside the State of Missouri, in every state except Virginia. Another policy, designated Automobile Owners Acrident and Family Hospital Policy, Form F-8-10-53, provides indemnity for loss of life or time due to certain automobile accidents and losses due to hospital expenses resulting from accidents and sickness. It was issued between August 10, 1953, and July 19, 1954, to 63,879 persons living outside Missouri in every state except Virginia. A third policy, Form No. 1-10-53, similar to the F-8-10-53 policy, was sold for a short period of time, but there are no specific charges in the complaint relating to the advertising of this policy.

3. Respondent has been soliciting business entirely by mail. It has used no newspaper, magazine, radio, television or other medium for its advertising. Respondent employed an affiliated company known as Automobile Owners Association, Inc., hereinafter referred to as the Association, as its exclusive agent for the solicitation of business. All advertising material was prepared by an advertising agency and approved by respondent.

4. Different form letters and application blanks were used in soliciting the sale of the two policies involved in this proceeding. The printing and mailing was by a Chicago mailing house. Such material was mailed from Chicago, Illinois, to persons located in every state except Virginia. Each solicitation letter, except in one special mailing, invited the recipient to join the Association provided he had not had an automobile accident in the preceding twelve months, and stated that as a member he would be entitled to apply through the Association for the particular policy mentioned in the letter. Each pros-

pective purchaser also received a return envelope and an application form which he was asked to fill out and return with the appropriate initial premium. In a special experimental mailing, the invitation to become a member of the Association was omitted from the form letter.

5. Completed applications with initial premium remittances, when received, were transmitted by the Association to respondent's underwriting department, which passed upon the application and issued the policies. Policy 1-29-53 was issued if the applicant for that policy had no automobile accident within the preceding twelve months. Policy F-8-10-53 was issued without further question if the application for that policy showed no medical consultations within the preceding three years; if such consultations were shown, then approval was based upon an estimate of the risk after further inquiry.

Upon issuance, policies were mailed to insureds with covering letters and premium receipts.

6. In a form letter relating to respondent's policy, form 1-29-53, and disseminated as indicated in Paragraph 4 above, the following statement is made:

> "* * * automobile accidents happen every day. If such a misfortune occurs and you are injured in an automobile accident, you can have an income of $100.00 a month for life, while you are at home under medical care or hospitalized. Our policy insures you while driving or riding in any automobile, bus, or truck, and provides these benefits:
>
> "1. *$100.00* a month beginning the first day you are injured. The policy provides that if you have an automobile accident and your are confined at home or in the hospital under medical care, you will be paid at the rate of $100.00 a month from the first day of injury even for life."

Respondent has represented by this statement, directly or indirectly, that any policyholder who is injured in an automobile accident will be indemnified in the amount of

$100 a month from the first day of injury for life, the only condition being that the policyholder is confined at home or in a hospital under medical care. We do not believe that the ambiguous language warrants construing the statement as containing the further condition or limitation that the policy insures the policyholder only while driving or riding in an automobile, bus or truck.

In truth and in fact, respondent's policies issued under form 1-29-53 do not so provide. Indemnification is made under such policies, by their terms, only against loss from injury sustained while driving or riding within any automobile, truck or bus and then only when such injury is

caused solely by reason of an automobile, truck or bus accident. Moreover, the policies provide that indemnification is payable only if the injury shall immediately after accident wholly and continuously disable and prevent the insured from performing any and every duty pertaining to any business or occupation and where, as the result thereof, the insured is thereby necessarily confined within doors and requires regular visits therein by a legally licensed medical or osteopathic physician or surgeon. In addition, the policies contain specific limitations and exclusions such as that the insurance does not cover any disability or loss unless sustained in the continental limits of the United States or Canada or that disability or loss resulting from military or naval service is not covered.

Respondent's representations as to the indemnification provided by its policies for injury or loss in an automobile accident are, therefore, misleading and deceptive. They state or suggest that a policyholder will be broadly protected as for life from such injury or loss with only one condition to be met, but the truth is that the policyholder is not so protected.

7. In a solicitation letter relating to policy F-8-10-53, disseminated as set forth in Paragraph 4, the following statements are made:

> "Hospitalization—$50.00 a week direct to you for 52 weeks if you are in the hospital for any sickness or any accident."
>
> "$50.00 a week if you have any sickness or accident that sends you to the hospital, even for one day. This $50.00 is sent to you every week for as long as 52 weeks—up to $2600.00."

Through such statements, respondent represents, directly or by implication, that the policies provide indemni-

fication for a period of 52 weeks if the insured is hospitalized from any sickness or any accident contracted or suffered.

In truth and in fact, respondent's policies issued under form F-8-10-53 do not so provide. The policies, by their terms, insure against loss resulting from sickness only when such sickness originates while the policy is in effect and more than fifteen days after the date of the policy. This denies benefits for hospitalization resulting from sickness traceable to a condition existing prior to or within fifteen days after the date of the policy.

Such policies also contain a number of exclusions or limitations including the following: The policies do not cover any disability or loss unless sustained in the United States or Canada, or that resulting from insanity or from military or naval service. They do not cover hospitalization for nervous or mental disorders or rest cures. Tuberculosis, cancer, diabetes, any heart or circulatory disease or disturbance, hernia, sickness or disease resulting in surgical operation, or sickness or disease of or involving organs which are peculiar to women are not covered if hospital confinement begins before the policy has been in force for six months.

Respondent's representations as to indemnification provided by its policies issued under form F-8-10-53 for losses from hospitalization for sickness or accident are, therefore, false and deceptive. They state or suggest in broad and general terms that the coverage is for *any* sickness or *any* accident, but the truth is, in view of the limitations and conditions in the policies, that hospitalization for some sicknesses and for some accidents is not covered.

8. Respondent has made the contention that disclosure of certain of the limitations in its advertising material is not required, since many of them have no effect on the payment of claims under the policies because respond-

ent interprets its policies liberally to the benefit of its policyholders, the Midsouri State Department of Insur-

ance discourages or forbids the interjection of technical defenses to obviate payment of claims, and ruling case law makes the limitations innocuous and ineffective. Respondent has further contended that if the policyholders receive the benefits that the Commission alleges respondent advertised, then any apparent provisions of the policy to the contrary are immaterial. The issue, however, is whether respondent's policies provide the benefits advertised rather than whether, by liberally interpreting policy provisions, respondent pays benefits which might not be collectible under a stricter interpretation of those provisions. Moreover, it is not clear that even a liberal interpretation of such provisions would eliminate their effect entirely. At the least, they might discourage in some instances the making of otherwise valid claims. The Commission finds that there is no merit in such contentions.

9. Respondent has also contended that the business of respondent is regulated by state law as that term is used in Public Law 15, 79th Congress, and hence the Federal Trade Commission Act is not applicable to respondent or its business. As previously noted, however, the respondent solicits sales of its policies solely by means of the mails among purhcasers residing in states other than Missouri, the only state in which it is licensed, and transmits them, when sold, to purchasers through the same channels. For reasons stated in the Commission's opinion in the matter of the *American Hospital and Life Insurance Company*, Docket No. 6237, we believe, and so find, that there is no merit in this contention of the respondent.

Conclusions

1. The Federal Trade Commission has jurisdiction over all the respondent's acts and practices found herein to be false and deceptive.

2. The public interest in this proceeding is clear and substantial.

3. The use by the respondent of the statements found in Paragraphs 6 and 7 above to be deceptive with respect to the terms and conditions of its policies of health and accident insurance, and its failure to reveal the limita-

tions of the coverage of said policies, have the tendency and capacity to mislead and deceive a substantial portion of the purchasing public into the erroneous and mistaken belief that said statements and representations are unqualifiedly true and to induce the purchase of said policies of insurance because of such erroneous and mistaken belief.

4. The aforesaid acts or practices of respondent, as above set forth, are all to the prejudice and injury of the public and constitute unfair and deceptive acts or practices within the intent and meaning of the Federal Trade Commission Act.

Order

It Is Ordered that respondent, Automobile Owners Safety Insurance Company, a corporation, and its officers, agents, representatives and employees, directly or through any corporate or other device, in connection with the offering for sale, sale and distribution in commerce, as "commerce" is defined in the Federal Trade Commission Act, of any accident, health, hospital or surgical insurance policy, do forthwith cease and desist from representing, directly or by implication, that said policy provides for indemnification against losses due to sickness or accident, unless a statement of all the conditions, exceptions, re-

strictions and limitations affecting the indemnification actually provided for are set forth conspicuously, prominently, and in sufficiently close conjunction with said representations as will fully relieve it of all capacity to deceive.

It Is Further Ordered that the respondent, Automobile Owners Safety Insurance Company, shall, within sixty (60) days after service upon it of this order, file with the Commission a report in writing setting forth in detail the manner and form in which it has complied with the order to cease and desist.

By the Commission, Chairman Gwynne dissenting.

Seal

s/ Robert M. Parrish
Robert M. Parrish,
Secretary.

Issued: April 26, 1957

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(385)

[Caption omitted]

Opinion of the Commission

By Secrest, Commissioner:

This matter is before the Commission upon the appeal of counsel supporting the complaint from the hearing examiner's initial decision filed October 4, 1956, dismissing the complaint without prejudice, and respondent's answer in opposition thereto.

The complaint charges respondent, Automobile Owners Safety Insurance Company, with violating the Federal Trade Commission Act, as that Act is applicable to the business of insurance under Public Law 15, 79th Congress (Title 15, U.S. Code, Sections 1011 and 1015), by disseminating false and misleading advertising relating to accident and health insurance policies which it has sold in commerce.

Respondent is a corporation doing business under the laws of the State of Missouri, with its office and principal place of business in Kansas City, Missouri. Respondent is licensed to engage in the business of insurance in Missouri, but in no other state. It sells accident and health insurance policies to purchasers and insureds

located in every state except Virginia. The record shows that respondent's manner of doing business has been through the use of the mails. Solicitation has been entirely by mail; no advertising by newspaper, magazine, radio, television or other medium has been used. The mailings have included form letters and application blanks. Upon the approval of applications, policies were issued and mailed to insureds.

The advertising representations at issue in this proceeding have been made with respect to the promotion of the sale of insurance policies issued under forms designated 1-29-53 and F-8-10-53.

In connection with the solicitation for policies issued under form 1-29-53, the following statement has been made in form letters disseminated by respondent:

> "* * * automobile accidents happen every day. If such a misfortune occurs and you are injured in an automobile accident, you can have an income of $100.00 a month for life, while you are at home under medical care or hospitalized. Our policy insures you while driving or riding in any automobile, bus, or truck, and provides these benefits:
>
> "1. $100.00 a month beginning the first day you are injured. The policy provides that if you have an automobile accident and you are confined at home or in the hospital under medical care, you will be paid at the rate of $100.00 a month from the first day of injury even for life."

The hearing examiner found that this statement did not disclose clearly the limitations and conditions in the policies such as, among others, that an automobile, truck or bus accident must have been the sole cause of injury or that the injury must have resulted in immediate disability. He concluded, therefore, that such advertising is unfair, misleading and deceptive.

(387)

The hearing examiner found, in addition, that representations contained in advertisements relating to the sale of policies issued under form F-8-10-53 were unfair and deceptive to the extent that not all of the exclusions, conditions and limitations in the policies are set forth conspicuously and prominently in such advertisements.

The complaint, however, was dismissed without prejudice by the hearing examiner on the ground that, under the circumstances, this would fully serve the public interest. The hearing examiner held that insofar as respondent has failed to comply with the requirements of the Federal Trade Commission Act, it has been by acts of omission rather than of commission; that respondent has demonstrated cooperation with the Commission; that the practices complained of were discontinued before the issuance of the complaint; that it is reasonable to assume that they will not be resumed; and that all that could be accomplished by an order has been accomplished. In addition, the examiner points out that there is no evidence that anyone has ever been deceived or misled by respondent's advertising.

Counsel supporting the complaint in their appeal argue the matter on the basis that the only question presented is in connection with the alleged discontinuance of the practices found to be unlawful. It is clear that the examiner considered other factors in arriving at his decision, but it is possibly fair to say that his conclusion as to the alleged discontinuance was the most important; otherwise there would be no sufficient grounds for di-

missal. For one thing, we cannot agree with the hearing examiner that the acts of the respondent found to be unlawful were acts of omission. The respondent has represented in a positive manner, by its advertising, that its policies provide insurance coverage which they do not in fact provide. Thus, this matter is not strictly one of failing to reveal limitations and conditions, even though the disclosing thereof would have prevented the advertising from being deceptive. This matter involves affirmative statements which are false or misleading and deceptive. We believe, therefore, the examiner erred to the extent that he did not so find.

(388)

Furthermore, the examiner's holding that the evidence fails to show that anyone has been deceived or misled relates to a subject which cannot be controlling. As we stated in the *National Casualty Company*, Docket No. 6311, it is not necessary that actual deception be proved or found under Section 5 of the Federal Trade Commission Act. A showing that the advertisements in question have a tendency or capacity to deceive is all that is required.

The other circumstances mentioned by the hearing examiner relate to the showing of the alleged discontinuance of the practices found to be unlawful or to the likelihood that they will not be resumed in the future. Respondent's past cooperation with the Commission is relevant only in so far as it might indicate that respondent is not likely to resume such practices. The essential question before the Commission, therefore, is whether or not the showing in the record relative to the abandonment or the discontinuance of the practices found to be unlawful is of such a nature as to warrant dismissal of the complaint.

In approaching this question, the first consideration is that the Commission, under Section 5 of the Federal Trade Commission Act, has a duty to prevent the use

of unfair methods of competition in commerce, and unfair or deceptive acts or practices in commerce. The law provides only one effective method by which the Commission may discharge its duty and that is by the issuance of an appropriate order to cease and desist. The object, of course, is to stop the unfair practice. Therefore, in the somewhat exceptional circumstances where the practice has been surely stopped by the act of the party offending and the object of the proceeding has been attained, no order is necessary, nor should one be entered.

If, however, the action of the wrongdoer does not insure a cessation of the practice in the future, an order to cease and desist is appropriate. *Eugene Dietzgen Co. v. Federal Trade Commission*, 142 F.2d 321. The Commission has a broad discretion in making any such determination, although it must be a reasonable exercise of discretion.

(389)

In this instance, superficial circumstances may seem to present a good cause for dismissal. Several months prior to the issuance of the complaint, respondent discontinued the use of the particular policy forms with which its unfair advertising was connected, and with this discontinuance respondent would have us find that all such unfair advertising had ceased, particularly since no evidence of repetition of the practices at a later date was introduced into the record.

The Commission, however, in view of its primary duty, must concern itself with factors other than a mere outward manifestation. In other words, we must inquire into whether or not the discontinuance is one of real substance. Does it have a high degree of finality so as to merit consideration for the exceptional treatment of a dismissal? There are some cases which are relatively obvious in this respect, such as where the discontinuance takes place long before the complaint issued or where there has been an abandonment of the entire method or type of business. No such circumstances are shown in

this instance. Respondent stopped using the particular policy forms here involved in the very shadow of Commission action and after the Commission had instituted a general investigation of advertising practices in the accident and health insurance industry. There has been no showing of any discontinuance of the type of insurance coverage contained in such policy forms. Considering all the circumstances, we must conclude that there is little in this record to suggest that the unlawful practices have been finally and definitely discontinued. Conversely, there is no assurance that practices which have not been surely stopped will not be resumed in the future. We believe, therefore, that respondent should be prohibited by an appropriate order from again engaging in the practices found to be unlawful.

The appeal of counsel supporting the complaint is granted. Accordingly, the initial decision is vacated and set aside, and our findings as to the facts, made on the whole record including the initial decision, and conclusions and order to cease and desist, are issuing in lieu thereof.

Chairman Gwynne dissented to the decision herein.

April 26, 1957.

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(390)

[Caption omitted]

Concurring Opinion of Commissioner Tait

It is my view that the Commission has jurisdiction herein for the reasons outlined in the concurring opinion in *Travelers Health Association*, Docket 6252, and the dissenting opinion in *North American Accident Insurance Company*, Docket 6456. It also should be noted that the respondent concedes "that it has violated the law and that the Commission has jurisdiction."

The order should be limited accordingly.

April 26, 1957

Commission EXH. 25-A

AUTOMOBILE OWNER'S ACCIDENT and HOSPITAL POLICY

This policy provides indemnity for Loss of Life or Time from Accidental Bodily injury, as the result of Accidents by Automobile, Truck, or Bus, as Herein Limited and Provided and is Non-Cancellable and Guaranteed Renewable to the age of 80 years.

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY

KANSAS CITY, MISSOURI

(HEREINAFTER CALLED THE COMPANY)

Accidental Death Indemnity	Hospital Expenses Maximum	Monthly Accident Benefits
$1000.00	$300.00	$100.00

Does Hereby Insure

.....(Hereinafter called the Insured)

whose beneficiary is ..... who is the .....

of the Insured. This policy is issued for a period of one full year from its date of issue, and may be renewed for such further periods as the renewal premiums paid by the Insured in advance will maintain the policy in force, provided, however, that renewal of this policy for any period commencing after the Insured attains the age of 80 years shall be at the option of the Company only. All periods of insurance hereunder shall begin and end at 12:01 o'clock noon, standard time, at the place where the Insured resides.

THIS IS A LIMITED POLICY READ CAREFULLY

THE INSURING CLAUSE

Part One

Against loss from accidental bodily injury sustained while driving or riding within any automobile, truck or bus for business or pleasure during the term of this policy, provided such bodily injuries are caused solely by reason of an automobile, truck or bus accident.

IN WITNESS WHEREOF, AUTOMOBILE OWNER'S SAFETY INSURANCE COMPANY has caused this policy to be executed at its office in Kansas City, Mo.

.....

(The date of issue)

AUTOMOBILE OWNERS SAFETY INSURANCE CO. MISSOURI CORPORATE SEAL

Maurice E. Benson
President

H. J. Healy
Secretary

Form No. 1-29-53

Part Two **PAYMENT FOR LOSS OF LIFE**

If the Insured shall sustain "Such Injury" as described in the Insuring Clause and not hereinafter excepted, which shall directly and independently of all other causes result in death within sixty (60) days from the date of accident, the Company will pay the sum of One Thousand Dollars ($1000.00).

Part Three **TOTAL CONFINEMENT BENEFITS FOR LIFE—AUTOMOBILE ACCIDENTS**

If "Such Injury" as described in the Insuring Clause, and not hereinafter excepted or for which indemnity is provided in Part Two, shall immediately after accident wholly and continuously disable and prevent the Insured from performing any and every duty pertaining to any business or occupation, and as the result thereof is thereby necessarily confined within doors and requires regular visits therein by a legally licensed medical or osteopathic physician or surgeon, the Company will pay for any one accident an idemnity for one day or more at the rate of One Hundred Dollars ($100.00) per month even for life, so long as such disability and confinement continues.

Part Four **MAXIMUM ADDITIONAL INDEMNITY IF CONFINED TO HOSPITAL**

(A) (HOSPITAL RESIDENCE INDEMNITY). If "Such Injuries" as are covered by the policy shall necessarily confine the Insured to a lawfully operated hospital as an emergency or resident patient for treatment therein, and the Insured shall thereby be regularly attended by a legally licensed medical or osteopathic physician or surgeon, other than himself, the Company will pay the Insured the expenses actually incurred for such hospital services for one day or more, resulting from any one accident, an amount not exceeding SIX DOLLARS PER DAY for a period not to exceed FIFTY DAYS. This indemnity is in addition to ... thly Accident Indemnity payable hereunder.

MEDICAL FIRST AID

If "Such Injury" makes necessary immediate first-aid treatment by a licensed physician or surgeon the Company will pay the actual cost of such treatment in an amount not to exceed Ten Dollars ($10.00). This benefit is in addition to any other benefit under the policy.

(B) The Insured hereunder shall have the sole right to choose his own physician or surgeon other than himself, and to select his own hospital, and the physician-patient relationship shall be maintained. The Company shall have the right before payment of any claim hereunder, to examine the hospital chart or other record of operation or disability upon which claim is based.

(C) No payment shall be made to an Insured for hospital indemnity provided herein unless actually necessary and recommended by a legally licensed medical or osteopathic physician or surgeon, other than himself.

Part Five **EXCLUSIONS AND LIMITATIONS**

Part Five **EXCLUSIONS AND LIMITATIONS**

1. This insurance does not cover any disability or loss (1) unless sustained in the Continental limits of the United States or Dominion of Canada, nor (2) resulting from the Insured being under the influence of intoxicants or narcotics, nor (3) while participating in or attempting to commit a felony, or to which a contributing cause was the Insured's being engaged in an illegal occupation, nor (4) resulting from Military or Naval Service.

Part Six **STANDARD PROVISIONS**

1. This policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance. No reduction shall be made in any indemnity herein provided by reason of change in the occupation of the Insured or by reason of his doing any act or thing pertaining to any other occupation.

2. No statement made by the applicant for insurance not included herein shall void the policy or be used in any legal proceeding hereunder. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an executive officer of the Company and such approval be endorsed herein.

3. If default be made in the payment of the agreed premium for this policy, the subsequent acceptance of a premium by the Company or by any of its duly authorized agents shall reinstate the policy, but only to cover loss resulting from accidental injury thereafter sustained.

4. Written notice of injury on which claim may be based must be given to the Company within twenty (20) days after the date of the accident causing such injury. In event of accidental death immediate notice thereof must be given to the Company.

5. Such notice given by or in behalf of the Insured or beneficiary, as the case may be, to the Company at Kansas City, Mo., with particulars sufficient to identify the Insured, shall be deemed to be notice to the Company. Failure to give notice within the time provided in this policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

6. The Company, upon receipt of such notice, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within fifteen (15) days after the receipt of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, character and extent of the loss of which claim is made.

7. Affirmative proof of loss must be furnished to the Company at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the Company is liable, and in case of claim for any loss within ninety (90) days after the date of such loss.

8. The Company shall have the right and opportunity to examine the person of the Insured when and so often as it may reasonably require during the pendency of claim hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

9. All benefits provided in this policy for loss will be paid within sixty (60) days after receipt of due proof.

10. Upon request of the Insured and subject to due proof of loss, all accrued indemnity for loss of time on account of disability will be paid at the expiration of each thirty (30) days during the continuance of the period for which the Company is liable, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof.

11. Benefit for loss of life of the Insured is payable to the beneficiary if surviving the Insured and otherwise to the estate of the Insured. All other indemnities of this policy are payable to the Insured.

12. If the Insured shall at any time change his occupation to one classified by the Company as less hazardous than that stated in the policy, the Company, upon written request of the Insured and surrender of the policy will cancel the same and will return to the Insured the unearned premium.

13. Consent of the beneficiary shall not be requisite to surrender or assignment of this policy or to change of beneficiary, or to any other changes in the policy.

14. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this policy, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of loss is required by the policy.

15. If any time limitation of this policy with respect to giving notice of claim or furnishing proof of loss is less than that permitted by the law of the state in which the Insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

Part Seven — **ADDITIONAL PROVISIONS**

Part Seven **ADDITIONAL PROVISIONS**

1. Refund of Premium — If this Policy is not satisfactory, it may be returned within ten (10) days from its date to the office through which it was issued or to the Home Office of the Company, and any premium paid hereon will be refunded.

2. If the Insured is disabled more than thirty (30) days, he or his representative shall furnish the Company every thirty (30) days with a report in writing from his attending physician or surgeon, fully stating the condition of the Insured and the probable duration of the disability.

3. No provision of the charter or by-laws of the Company not included herein shall void the policy nor be used in any legal proceedings hereunder.

4. This policy will not be in force unless and until the first premium has actually been received at the office through which the policy is issued and the Company's receipt issued therefor. If not in force as aforesaid, the extent of the Company's liability shall be the return of the premium paid. If any subsequent premium payment be not received by the Company, or paid to an authorized agent of the Company, or deposited in the United States mail, addressed to the Company, on or before the date when due or within the grace period provided herein, this policy and all benefits hereunder shall terminate without further notice; provided, however, such termination shall be without prejudice to any claim originating prior thereto. Premiums may be paid only in exchange for an official receipt issued by the Company.

5. After two years from the date of issuance or two years from the date of last reinstatement, this policy shall be incontestable, except for non-payment of premiums.

6. If any time limitation of this Policy with respect to the bringing of an action at law or in equity is less than that permitted by the law of the state in which the Insured resides at the time this Policy is issued such limitation is hereby extended to agree with the minimum period permitted by such law.

7. The Company agrees (1) that this policy shall be construed and interpreted in accordance with the law of the state in which the Insured resides, in the same manner as if the policy were a contract made in said state; (2) that upon request of the Insured or of the Insured's counsel it will voluntarily appear and submit itself to the jurisdiction of any court of the state of the Insured's residence having jurisdiction of the subject matter for the purpose of litigating any dispute that may arise between the Company and the Insured with respect to this policy; and (3) that in the event of the failure of the Company so to appear and submit itself to the jurisdiction of said court, proof submitted to said court that such appearance has been requested by the Insured or by the Insured's counsel, by registered mail, return receipt requested, at least thirty days prior to the return of said action, shall be sufficient proof of notice to the Company to give said court jurisdiction of the Company for the purpose of this agreement, provided under the laws of said state, the Company is permitted to make a defense.

Part Eight **CONSIDERATION**

1. The consideration for this policy is the application therefor, and the payment in advance of the required premium of $5.00 for one full year, provided the applicant has not had an automobile accident while driving in the twelve months preceding the date of this application.

2. This policy may be renewed upon the payment of a premium of $5.00 for a full year with a grace period of ten (10) days for the payment of any subsequent premium after the first, provided, however, that renewal of the policy for any period commencing after the Insured attains the age of 80 years shall be at the option of the Company only.

All communications regarding this insurance must give Number of Policy

Do Not Destroy This Policy. It is valuable. Keep it in a safe place and in continuous force by paying the premiums promptly

DRIVE CAREFULLY

REMEMBER-THE LIFE YOU SAVE MAY BE YOUR OWN!

Automobile Owner's Accident and Hospital Policy

THIS POLICY PAYS—

$100.00 a month for Accident Benefits beginning the first day you are injured continuing even for life.

$500.00 Maximum for Hospital Expenses in any hospital in the U.S. or Canada.

$1000.00 for your beneficiaries in case of accidental loss of life.

Automobile Owners Safety Insurance Company

KANSAS CITY, MO.

This policy provides indemnity for loss of life or time from accidental bodily injury, as the result of accidents while driving or riding within any automobile, truck or bus as herein limited and provided, and is non-cancellable and guaranteed renewable to the age of 80 years.

THIS POLICY IS NONASSESSABLE

Form No. 1-B-53

REGISTER OF CHANGE OF BENEFICIARY

Note—No change, designation or declaration shall take effect until endorsed on this policy by the Company at the Home Office

DATE ENDORSED	BENEFICIARY	ENDORSED BY

IMPORTANT NOTICE

Written notice should be given the Company in the event of accidental death or disability from automobile accident as required by the policy

Commission Exhibit 9

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY
1319 Walnut Street Kansas City 6, Missouri.

February, 1954

Dear Friend:

If you are a careful automobile driver who has not had an automobile accident in the past twelve months, you are eligible to apply for our Automobile Owner's Acident and Hospital Policy at a very low rate.

MILLIONS OF DOLLARS have been refunded by insurance companies yearly to auto owners who were careful drivers who had not had an automobile accident during the past twelve months. *OUR PLAN*, instead of refunding at the end of the year for careful driving, rewards you in advance with an Automobile Owner's Accident and Hospital Policy at the low premium rate of $5.00 for one full year's insurance.

No matter how careful a driver you may be, automobile accidents happen every day. If such a misfortune occurs and you are injured in an automobile accident, you can have an income of $100.00 a month for life, while you are at home under medical care or hospitalized. Our policy insures you while driving or riding in any automobile, bus, or truck, and provides these benefits:

1. *$100.00* a month beginning the first day you are injured. The policy provides that if you have an automobile accident and you are confined at home or in the hospital under medical care, you will be paid at the rate of $100.00 a month from the first day of injury even for life.

2. *$300.00* for hospital expenses in any hospital in the U.S. or Canada. $6.00 per day from the very first day of hospitalization up to $300.00. (This is in addition to the regular $100.00 monthly income).

3. *$1,000.00* for your beneficiaries in case of accidental loss of life.

How can this policy be offered at such a low cost? *The answer is simple.* Careless drivers cause 90% of all automobile accidents. If you are a careful auto driver you are a PREFERRED RISK, and there is no reason for you to pay the same rate as a careless driver.

Members are entitled to our Automobile Owner's Accident & Hospital Policy at the low premium rate of $5.00 for one full year's insurance. (No medical examination).

THIS POLICY PAYS—NO MATTER WHAT YOU COLLECT FROM COMPENSATION OR OTHER INSURANCE. You owe it to yourself and your family to get this low cost *extra* protection. It's the only policy of its kind written by any insurance company at this *low premium rate.*

Mail $5.00 *TODAY* with the enclosed application for one full year's insurance, and join the many satisfied policy owners in your state. Your policy will be mailed to you immediately upon approval of

Examine it for 10 days. If you are not entirely satisfied, simply return the policy and your money will be refunded with no questions asked.

Sincerely yours,

AUTOMOBILE OWNER'S SAFETY INSURANCE COMPANY

President

THIS POLICY IS AVAILABLE TO YOU AT $5.00 FOR ONE FULL YEAR'S INSURANCE. YOUR APPLICATION IS EXPECTED TO REACH OUR OFFICE NOT LATER THAN FEBRUARY 19, 1954.

MEB:JH

$100.00 A MONTH INCOME FOR LIFE

Automobile Owner's Accident and Hospital Policy

To: AUTOMOBILE OWNER'S SAFETY INSURANCE COMPANY—1319 Walnut St., Kansas City 6, Mo.
I am enclosing $5.00 in payment of One Full Year's Premium for an AUTOMOBILE OWNER'S ACCIDENT and HOSPITAL POLICY. I have not had an automobile accident in the past 12 months.

Full Name _____ Occupation _____

Address _____ City _____ State _____

Name of Beneficiary _____ Relationship _____

Age _____ Write your own name here _____

I understand if I am not satisfied with this Policy upon receipt I will return it, and my $5.00 will be promptly refunded without any question. Make all checks or money orders payable to AUTOMOBILE OWNER'S SAFETY INSURANCE COMPANY

MEN AND WOMEN • AGES 18 TO 80 • NO MEDICAL EXAMINATION

APPLICATION FOR

Form No. Series

$100.00 A MONTH INCOME FOR LIFE

This Automobile Owner's Accident and Hospital Policy

- **PAYS YOU $100.00** a month beginning the first day you are injured. The policy provides that if you have an automobile accident while driving or riding in any automobile, truck or bus, and you are confined at home or in the hospital under medical care, you will be paid at the rate of $100.00 a month from the first day of injury, even for life.
- **PAYS YOU $300.00** for hospital expenses in any hospital in the U. S. or Canada. $6.00 per day from the very first day of hospitalization up to $300.00. (This is in addition to the regular $100.00 monthly income.)
- **PAYS $1,000.00** to your beneficiaries in case of accidental loss of life.

COSTS YOU $5.00

for One Full Year insurance

★ **PROMPT PAYMENT OF CLAIMS**
You can depend on the Company's responsibility

★ **AUTOMOBILE OWNERS SAFETY INSURANCE CO.** is under the supervision of the Missouri State Department of Insurance, no assessments, and is managed by men of ability with long experience in the Insurance Field.

★ The Company has over Five Hundred Thousand dollars ($500,000.00) in cash and U. S. Govt. Bonds for the protection of all policyholders.

OVER 100,000 SATISFIED POLICYHOLDERS

Reference: Southeast State Bank

HOW CLAIMS ARE PAID

1. Notify us promptly of automobile accident. No details are necessary.
2. We will send you by return mail an automobile accident claim form.
3. Return form properly filled out together with licensed physician's report of injury.
4. Our check will be mailed to you promptly on approval of your claim.

Commission EXH. 33

Automobile Owner's Accident and Family Hospital Policy

This policy provides indemnity for loss of life or time from accidental bodily injury, as the result of accidents while driving or riding within any automobile, truck, or bus, as herein limited and provided, and provides benefits for loss due to hospital confinement and for other specified expense resulting from any accidental bodily injury and sickness, to the extent herein limited and provided. This policy is noncancellable and guaranteed renewable to age 75.

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY

KANSAS CITY, MISSOURI
(Hereinafter called the Company)

Accidental Death Indemnity	HOSPITALIZATION SICKNESS OR ACCIDENTS	Monthly Accident Benefits
$1,000.00	$50.00 A WEEK	$100.00

_____ (Hereinafter called the Insured)

whose beneficiary is _____ who is the _____

of the Insured, and all members of the Insured's family, if any, named in Schedule A (all of whom, including the Insured, are hereinafter called the Family Group).

SCHEDULE A

NAME	AGE	EFFECTIVE DATE	PREMIUM	INITIAL TERM
INSURED			$	

This policy is dated and takes effect on the date shown in Schedule A on face hereof and continues in effect for the term for which premium is paid; it may be renewed for further consecutive periods by the payment in advance of renewal premiums to age 75. After age 75, it may be renewed at the option of the Company. All periods of insurance shall begin and end at twelve o'clock noon, Standard Time, at the residence of the Insured.

PART ONE — THE INSURING CLAUSE

This Policy insures, subject to all provisions and limitations herein contained:

(a) Against loss from accidental bodily injury sustained while driving or riding within any automobile, truck or bus for business or pleasure during the term of this policy, provided such bodily injuries are caused solely by reason of an automobile, truck or bus accident, hereinafter referred to as "such auto injury"; and

(b) resulting from any accidental bodily injury sustained while this policy is in effect, hereinafter referred to as "such injury"; and

(c) resulting from sickness which originates while this policy is in effect and more than fifteen days after the date hereof, hereinafter referred to as "such sickness".

PART TWO — PAYMENT FOR ACCIDENTAL LOSS OF LIFE

If the Insured, or any member of the Family included under this contract and over the age of eighteen years, shall sustain "Such Auto Injury" as described in the Insuring Clause and not hereinafter excepted, which shall directly and independently of all other causes result in death within sixty (60) days from the date of accident, the Company will pay the sum of One Thousand Dollars ($1,000.00).

(b) If the Insured be under the age of eighteen years (18) the amount payable shall be Five Hundred Dollars ($500.00).

PART THREE — ACCIDENTAL DEATH BENEFIT FOR SPECIFIED ACCIDENTS $5,000.00

(a) If the covered injuries are received while the insured is riding as a fare paying passenger within the enclosed part of any railway passenger car or street railway car, or within the enclosed part of any bus operated on a regular schedule between designated stations and provided by a common carrier for passenger service and such injuries shall result in the death of the insured within sixty (60) days after the date of the accident, the Company will pay the designated beneficiary the sum of five thousand dollars ($5,000).

(b) If the Insured be under the age of 18 years, the amount payable shall be twenty-five hundred dollars ($2,500.00).

SPECIMEN POLICY

PART FOUR **TOTAL CONFINEMENT BENEFITS FOR LIFE —AUTOMOBILE ACCIDENTS**

If "Such Auto Injury" as described in the Insuring Clause, and not hereinafter excepted or for which indemnity is provided in Part Two shall immediately after accident wholly and continuously disable and prevent the Insured, or any member of the Family, included in the Insured Group under this Policy, from performing any and every duty pertaining to any business or occupation, and as the result thereof is thereby necessarily confined within doors and requires regular medical treatment by a legally licensed medical or osteopathic physician or surgeon, the Company will pay for any one accident an indemnity for one day or more, at the rate of One Hundred Dollars ($100.00) per month if the Insured be over 18 years of age or Fifty Dollars ($50.00) per month if the Insured be under 18 years of age, even for life, so long as such disability and confinement continues.

PART FIVE **MEDICAL FIRST AID**

If "Such Auto Injury" makes necessary immediate first-aid treatment by a licensed physician or surgeon the Company will pay the actual cost of such treatment in an amount not to exceed Ten Dollars ($10.00). This benefit is in addition to any other benefit under the policy.

PART SIX **HOSPITAL CONFINEMENT BENEFITS**

a. ADULTS. If the Insured or any member of the Family Group shall be necessarily confined to a hospital as a result of "such injury" or "such sickness" for which benefits are payable and is over eighteen (18) years of age and under age seventy-five (75), the Company will pay for each and every day of such confinement, beginning with the first full day of such confinement, at the rate of Fifty Dollars ($50.00) a week not to exceed fifty-two (52) weeks. Total not to exceed $2,600.00. If the Policy is renewed with the consent of the Company after the seventy-fifth (75th) birthday, the benefits will be the same as provided herein.

b. MINORS. If any member of the Family Group under age eighteen (18) years shall be necessarily confined to a hospital as the result of "such injury" or "such sickness" for which benefits are payable, the Company will pay for each and every day of such confinement, beginning with the first full day of such confinement, at the rate of Twenty five Dollars ($25.00) a week, not to exceed fifty-two (52) weeks. Total not to exceed $1,300.00.

c. BENEFIT FOR MATERNITY. If the insured whose legal husband is also included under this Family Hospital Policy shall be confined within a hospital as a result of pregnancy, miscarriage or complication therefrom after this policy shall have been in effect for not less than ten (10) months from the date hereof, the Company will pay the insured at the rate of fifty dollars ($50.00) per week, not to exceed four (4) weeks. Total not to exceed two hundred dollars ($200.00).

PART SEVEN **INDEMNITY FOR HOSPITAL AND OTHER SPECIFIC LOSSES RESULTING FROM POLIOMYELITIS (INFANTILE PARALYSIS)**

a. DOCTOR'S BILLS

IF ANY MEMBER OF THE FAMILY GROUP shall be necessarily confined to a hospital and require medical treatment from a licensed physician for a condition diagnosed as Poliomyelitis (Infantile Paralysis), the Company will pay the actual expenses incurred for such medical treatment during such hospital confinement not exceeding Five Hundred Dollars ($500.00).

b. HOSPITAL EXPENSE

IF ANY MEMBER OF THE FAMILY GROUP shall be necessarily confined to a hospital for a condition diagnosed as Poliomyelitis (Infantile Paralysis), the Company will pay the actual expense incurred by such confinement not exceeding Five Hundred Dollars ($500.00).

c. ORTHOPEDIC APPLIANCES

c. ORTHOPEDIC APPLIANCES

IF ANY MEMBER OF THE FAMILY GROUP shall require by order of a licensed physician, orthopedic appliances for the purpose of correcting or treating a deformity resulting from Poliomyelitis (Infantile Paralysis), the Company will pay the actual expense incurred therefor not exceeding Five Hundred Dollars ($500.00).

Indemnities under Part Seven shall be IN LIEU of and not in addition to any other indemnities which might otherwise be payable for hospital confinement and services as a result of Poliomyelitis (Infantile Paralysis).

PART EIGHT — DEFINITION OF "HOSPITAL"

The term "hospital" as used in this policy shall mean a lawfully-operating institution for the care and treatment of sick and injured persons, with organized facilities for diagnosis and treatment, medical supervision, major surgery and twenty-four hour nursing service, but does not include any government hospital, rest homes or institutions for the care and treatment of the mentally diseased.

PART NINE — FREE CHOICE OF PHYSICIAN OR SURGEON

All persons shall have free choice of physician or surgeon, legally practicing, and the doctor-patient relationship shall be maintained at all times.

PART TEN — COMMERCIAL AIR TRAVEL PASSENGER COVERAGE

This policy covers "such injury" caused by any of the hazards of aviation, aeronautics or air travel, only if received while the Insured or any member of the Family Group is riding as a fare-paying passenger in a licensed passenger airplane provided by an incorporated common carrier of passengers and while operated by a licensed transport pilot upon a regular scheduled passenger route between definitely established airports.

PART ELEVEN — GRACE PERIOD

A grace period of fifteen days, without interest charge, will be allowed for the payment of renewal premiums, during which grace period the insurance hereunder shall continue in effect, subject otherwise to all of the terms and provisions of this policy.

PART TWELVE — EXCLUSIONS AND LIMITATIONS

a. No payment shall be made for hospital indemnity provided herein unless actually necessary and recommended by a legally licensed medical or osteopathic physician or surgeon, other than the Insured.

b. This policy does not cover any disability or loss (1) unless sustained in the United States or Canada, nor (2) resulting from the Insured being under the influence of intoxicants or narcotics, nor (3) resulting from syphilis or venereal disease, nor (4) resulting from insanity or any attempt at suicide, nor (5) while participating in or attempting to commit a felony, or to which a contributing cause was the Insured's being engaged in an illegal occupation, nor (6) resulting from Military or Naval Service. The pro rata unearned premium for any period not covered while in Military or Naval Service will be returned.

c. This policy does not cover hospitalization for nervous or mental disorders, rest cures or alcoholism.

d. Tuberculosis, cancer, diabetes, any heart or circulatory disease or disturbance, hernia of any type, sickness or disease resulting in a surgical operation, sickness or disease of or involving organs which are peculiar to women, shall be covered only if hospital confinement begins after this policy has been in force for six months or more from the date hereof.

PART THIRTEEN — STANDARD PROVISIONS

1. This policy includes the endorsements and attached papers, if any, and contains the entire contract of insurance. No reduction shall be made in any indemnity herein provided by reason of change in the occupation of the Insured or by reason of his doing any act or thing pertaining to any other occupation.

2. No statement made by the applicant for insurance not included herein shall void the policy or be used in any legal proceeding hereunder. No agent has authority to change this policy or to waive any of its provisions. No change in this policy shall be valid unless approved by an executive officer of the Company and such approval be endorsed herein.

3. If default be made in the payment of the agreed premium for this policy, the subsequent acceptance of a premium by the Company or by any of its duly authorized agents shall reinstate the policy, but only to cover loss resulting from accidental injury thereafter sustained and such sickness as may begin more than ten days after the date of such acceptance.

4. Written notice of Injury or of Sickness on which claim may be based must be given to the Company within twenty (20) days after the date of the accident causing such injury. In event of accidental death immediate notice thereof must be given to the Company.

5. Such notice given by or in behalf of the Insured or beneficiary, as the case may be, to the Company at Kansas City, Mo., with particulars sufficient to identify the Insured, shall be deemed to be notice to the Company. Failure to give notice within the time provided in this policy shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

6. The Company, upon receipt of such notice, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not so furnished within fifteen (15) days after the receipt of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time fixed in the policy for filing proofs of loss, written proof covering the occurence, character and extent of the loss for which claim is made.

7. Affirmative proof of loss must be furnished to the Company at its said office in case of claim for loss of time from disability within ninety days after the termination of the period for which the Company is liable, and in case of claim for any loss, within ninety (90) days after the date of such loss.

8. The Company shall have the right and opportunity to examine the person of the Insured when and so often as it may reasonably require during the pendency of claim hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

9. All benefits provided in this policy for loss will be paid within sixty (60) days after receipt of due proof.

10. Upon request of the Insured and subject to due proof of loss, all accrued indemnity for loss of time on account of disability will be paid at the expiration of each thirty (30) days during the continuance of the period for which the Company is liable, and any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of due proof.

11. Benefit for loss of life of the Insured is payable to the beneficiary if surviving the Insured and otherwise to the estate of the Insured. All other indemnities of this policy are payable to the Insured.

12. If the Insured shall at any time change his occupation to one classified by the Company as less hazardous than that stated in the policy, the Company, upon written request of the Insured and surrender of the policy will cancel the same and will return to the Insured the unearned premium.

13. Consent of the beneficiary shall not be requisite to surrender or assignment of this policy or to change of beneficiary, or to any other changes in the policy.

14. No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of this policy, nor shall such action be brought at all unless brought within two years from the expiration of the time within which proof of loss is required by the policy.

15. If any time limitation of this policy with respect to giving notice of claim or furnishing proof of loss is less than that permitted by the law of the state in which the Insured resides at the time this policy is issued, such limitation is hereby extended to agree with the minimum period permitted by such law.

PART FOURTEEN ADDITIONAL PROVISIONS

PART FOURTEEN — ADDITIONAL PROVISIONS

1. **Refund of Premium**—If this Policy is not satisfactory, it may be returned within ten (10) days from its date to the office through which it was issued or to the Home Office of the Company, and any premium paid hereon will be refunded. If not so returned, the policyholder shall be deemed to have accepted the policy and to have agreed to be bound by its terms, provisions and conditions.

2. If the Insured is disabled more than thirty (30) days, he or his representative shall furnish the Company every thirty (30) days with a report in writing from his attending physician or surgeon, fully stating the condition of the Insured and the probable duration of the disability.

3. This contract is made with the Insured who has signed the application herefor. Such Insured is the beneficiary of all members of the Family Group other than himself, and every transaction relating to this policy shall be between the Company and such Insured.

4. Additional new members may be added to the Family Group from time to time by the Insured upon written application therefor, with evidence of eligibility and insurability satisfactory to the Company, and upon payment of the required premiums for such additional new members. The acceptance of such members shall be shown by an endorsement affixed to the policy and the date thereof shall constitute the date of the policy with respect to such new members.

5. This policy is issued in consideration of the statements made by the Insured in the application herefor, and the payment in advance of the premium for the initial term, provided all members of the Family Group have not had an automobile accident while driving in the twelve months preceding the date of this application. This policy shall take effect at 12 o'clock noon, Standard Time of the place where the Insured resides, and shall end at the same hour on the last day of grace following the date on which the initial term expires. The effective date of this policy, the initial premium therefor, and the date the initial term expires are shown in Schedule A on face hereof. This policy is renewable by the payment in advance or within the grace period provided herein, of the agreed renewal premium shown hereon to age 75. After age 75, it may be renewed at the option of the Company.

6. If any premium payment be not received by the Company, or paid to an authorized agent of the Company, or deposited in the United States mail, addressed to the Company, on or before the date when due or within the grace period provided herein, this policy and all benefits hereunder shall terminate without further notice; provided, however, such termination shall be without prejudice to any claim originating prior thereto. Premiums may be paid only in exchange for an official receipt issued by the Company.

7. Except for non-payment of premiums, this policy shall be incontestable after two years from the date of issuance.

8. "The Company agrees (1) that this policy shall be construed and interpreted in accordance with the law of the state in which the Insured resides, in the same manner as if the policy were a contract made in said state; (2) that upon request of the Insured or of the Insured's counsel it will voluntarily appear and submit itself to the jurisdiction of any court of the state of the Insured's residence having jurisdiction of the subject matter for the purpose of litigating any dispute that may arise between the Company and the Insured with respect to this policy; and (3) that in the event of the failure of the Company so to appear and submit itself to the jurisdiction of said court, proof submitted to said court that such appearance has been requested by the Insured or by the Insured's counsel, by registered mail, return receipt requested, at least thirty days prior to the return of said action, shall be sufficient proof of notice to the Company to give said court jurisdiction of the Company for the purpose of this agreement, provided under the laws of said state, the Company is permitted to make a defense."

IN WITNESS WHEREOF, the Company has caused this policy to be signed by its President and Secretary.

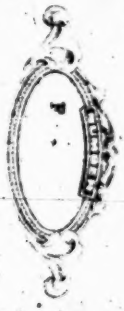
AUTOMOBILE DRIVERS SAFETY INSURANCE CO. CORPORATE SEAL MISSOURI

H. J. Lindley
Secretary

Maurice E. Benson
President

This policy provides indemnity for loss of life or time from accidental bodily injury, as the result of accidents while driving or riding within any automobile, truck, or bus, as herein limited and provided, and provides benefits for loss due to hospital confinement and for other specified expense resulting from accidental bodily injury and sickness, to the extent herein limited and provided. This policy is non-cancellable and guaranteed renewable to age 75.

Automobile Owner's
Accident and
Family Hospital Policy



Automobile Owners
Safety Insurance
Company

A LEGAL RESERVE

THIS IS A

Kansas City, Missouri

REGISTER OF CHANGE OF BENEFICIARY

Note.—No change, designation or declaration shall take effect until endorsed on this policy by the Company at the Home Office.

DATE ENDORSED	BENEFICIARY	ENDORSED BY

IMPORTANT NOTICE

Written notice should be given the Company in the event of accidental death or disability from automobile accident as required by the policy.

All communications regarding this Insurance must give Number of Policy.

DO NOT DESTROY THIS POLICY. It is valuable. Keep it in a safe place and in continuous force by paying the premiums promptly.

DRIVE CAREFULLY.

REMEMBER THE LIFE YOU SAVE MAY BE YOUR OWN!

AUTOMOBILE OWNER'S ASSOCIATION, INC.

1319 WALNUT STREET - KANSAS CITY 6, MISSOURI

A Nationwide Association that Encourages and Rewards Safe Driving

Dear Friend:

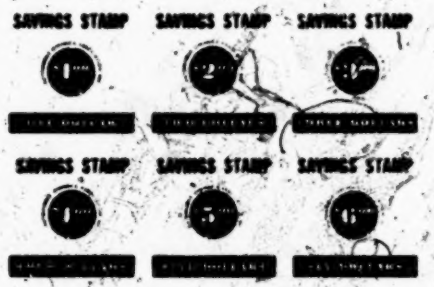
November, 1953

If you are a careful automobile driver who has not had an automobile accident in the past twelve months, you are invited to join our Association and encourage safe driving.

Membership is free, there are no dues or assessments. As a member you will be entitled to apply through the Association for an Automobile Owner's Accident and Hospital Policy, with all of its benefits.

MILLIONS OF DOLLARS have been refunded by insurance companies yearly to automobile owners who are careful drivers, and who have not had an automobile accident during the past 12 months.

SPECIAL SAVINGS STAMP OFFER FOR THIS MONTH



Our plan, instead of refunding at the end of the year for careful driving, rewards you in advance with an AUTOMOBILE OWNERS ACCIDENT & HOSPITAL POLICY at the low premium rate of $2.00 for one month's insurance.

AUTO ACCIDENTS -- No matter how careful a driver you may be, auto accidents happen every day. If such a misfortune occurs, and you are injured while driving or riding in any automobile, truck or bus you will receive an income of $100.00 a month for life.

HOSPITALIZATION -- $50.00 a week direct to you for 52 weeks if you are in the hospital for any sickness or any accident.

THIS AUTOMOBILE OWNERS ACCIDENT AND HOSPITAL POLICY PAYS:

1. $100.00 A MONTH FOR AUTOMOBILE ACCIDENTS beginning the first day you are injured, even for life! The policy provides that if you have an auto accident while driving or riding in any automobile, truck, or bus, and you are confined at home under medical care, for even one day, you will be paid at the rate of $100.00 a month for that one day, even for life! (If you are hospitalized, you will receive $300.00 a month) $1,000.00 AUTO DEATH BENEFIT.

(over)

2. $50.00 A WEEK IF YOU HAVE ANY SICKNESS OR ACCIDENT that sends you to the hospital, even for one day. This $50.00 is sent you every week for as long as 52 weeks - - up to $2600.00. This is in addition to the $100.00 regular monthly income.)

3. $1,500.00 POLIO CASH BENEFITS for any member of your family when stricken by Polio, for medical treatment, hospital expenses, orthopedic appliances, etc.

4. $5,000.00 PAID TO YOUR BENEFICIARY for loss of life while riding as a FARE-PAYING PASSENGER on a common carrier (train, bus or streetcar).

All the benefits are paid directly to you. You select your own hospital and your own doctor. Use the money this policy pays to suit yourself.

The cost of each adult member (age 18 to 65) is only $2.00 per month. Older ages (65 to 75) only $3.00 per month.

Children under 18 at one-half rate (pays one-half benefits).

How can this policy be offered at such a low cost? The answer is simple. Careless drivers cause 90% of all automobile accidents. If you are a careful auto driver there is no reason for you to pay the same rate as the careless one.

THIS POLICY PAYS - NO MATTER WHAT YOU COLLECT FROM COMPENSATION OR ANY OTHER INSURANCE.

Members who have not had an automobile accident in the past 12 months are eligible to apply for our AUTOMOBILE OWNERS ACCIDENT AND HOSPITAL POLICY at the low premium rate of $2.00 for one month's insurance. (No medical examination).

"SPECIAL SAVINGS STAMP OFFER"!! You are entitled to take advantage of our Special Savings Stamps Offer for this month. Just paste the proper stamp on the application in the box indicated. Then mail with only $1.00 for your first month's insurance regardless of how many persons are included in your application.

Your policy will be mailed to you immediately upon approval of application. Examine it for 10 days, (during which period you will be insured). If you are not entirely satisfied simply return the policy and your money will be refunded with no questions asked.

P.S. THIS POLICY IS AVAILABLE TO YOU AT $1.00 FOR THE FIRST MONTH'S INSURANCE PROVIDED YOUR APPLICATION REACHES OUR OFFICE NOT LATER THAN NOVEMBER 27, 1953.

Sincerely yours,

AUTOMOBILE OWNER'S ASSOCIATION, INC.

By M E Benson

President

MEB:JH

$100.00 A MONTH INCOME FOR LIFE PAID DIRECT TO YOU!

CAN YOU QUALIFY FOR THIS POLICY?

If you are in good health and have not had an automobile accident in the past 12 months, you may be eligible to qualify for this new AUTOMOBILE OWNER'S ACCIDENT & HOSPITAL POLICY—*at a very low premium rate.*

PROTECTS YOU AND YOUR FAMILY AGAINST ACCIDENTS—SICKNESS—HOSPITALIZATION—More Benefits! Greater Compensation! Never before such an all-embracing policy at such a nominal premium rate. This remarkable AUTOMOBILE OWNER'S ACCIDENT & HOSPITAL POLICY covers you and your family for about every kind of accident.

BENEFITS START FROM THE FIRST DAY OF INJURY—and common and rare disease benefits start when sickness originates after the policy has been in force for 15 days. Serious diseases, such as cancer, tuberculosis, heart disease, diseases involving female organs, and sickness resulting in serious operations are also fully covered after this policy is in force for 6 months. Suicide, insanity and venereal diseases are understandingly excluded.

CHOOSE YOUR OWN HOSPITAL CHOOSE YOUR OWN DOCTOR

You, yourself, choose your own hospital—your own doctor—anywhere in the United States or Canada—(government hospitals, rest homes, clinics, health resorts, or sanitariums are excluded). All benefits are sent directly to you unless you instruct us to pay some to hospital or doctor.

CLAIMS PROMPTLY PAID

You can depend on the Company's responsibility. AUTOMOBILE OWNER'S SAFETY INSURANCE COMPANY is under the supervision of the Missouri State Department of Insurance, no assessments, and is managed by men of ability, and with long experience in the insurance field.

The Company has over Three Hundred Thousand Dollars ($300,000.00) in cash and securities for the protection of all policy holders.

References:

Southeast State Bank

HOW CLAIMS ARE PAID

1. Notify us promptly of sickness or accident. No details are necessary.
2. We will send you by return mail a sickness or accident claim form.
3. Return form properly filled out together with hospital report.
4. Our check will be mailed to you promptly on approval of your claim.

The NEW AUTOMOBILE OWNERS ACCIDENT & HOSPITAL POLICY pays $100.00 a month direct to you for life if you are injured riding or driving in any automobile, truck or bus.

AUTO ACCIDENT INCOME BENEFITS

$100.00 A MONTH FOR AUTOMOBILE ACCIDENTS BEGINNING THE FIRST DAY YOU ARE INJURED, EVEN FOR LIFE while riding or driving in any automobile, truck, or bus. $1,000.00 AUTO DEATH BENEFIT.

HOSPITALIZATION BENEFITS

$50.00 A WEEK PAID DIRECT TO YOU WHILE IN THE HOSPITAL FROM SICKNESS OR ACCIDENT FROM ANY CAUSE from the first day of hospitalization for as long as 52 weeks up to $2,600.00.

POLIO EXPENSE BENEFITS

$1500.00 POLIO CASH BENEFITS FOR MEDICAL TREATMENT, HOSPITAL EXPENSES, ORTHOPEDIC APPLIANCES, ETC., for any member of your family when stricken with Polio.

LIBERAL DEATH BENEFITS

$5000 CASH PAYMENT TO YOUR FAMILY FOR DEATH DUE TO AN ACCIDENT WHILE RIDING AS A fare-paying passenger on a common carrier (train, bus, or streetcar).

NO OTHER INSURANCE POLICY GIVES YOU THE PROTECTION AND BENEFITS YOU GET WITH AUTOMOBILE OWNERS ACCIDENT & HOSPITAL POLICY

For example:

- We do not tell you how much to pay your doctor
- We do not tell you how much to pay for your hospital room
- We do not tell you how much to pay for X-rays
- We do not tell you how much to pay for Surgery

ALL BENEFITS ARE PAID DIRECT TO YOU—AND ARE YOURS TO USE AS YOU SEE FIT!

$2.00 a month for members 18 to 65.
$3.00 a month for members 65 to 75.
Children under 18 at one-half rate (pays one-half benefits).

FILL OUT APPLICATION ON REVERSE SIDE
MAIL TODAY! PROTECT YOURSELF & FAMILY

$50.00 — FROM ANY CAUSE

APPLICATION FOR INDIVIDUAL OR FAMILY

To: **AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,** 1319 Walnut Street, Kansas City 6, Missouri

I am enclosing $1.00 in payment for one month's insurance for an AUTOMOBILE OWNER'S ACCIDENT AND HOSPITAL POLICY.

I have not had an automobile accident in the past 12 months.

Name of Applicant _____ Occupation _____ Age _____
(Please print carefully)

Address _____ City _____ State _____

Name of Beneficiary _____ Age _____ Relationship _____

Please print full names of members of family whom you wish included in this policy—

First Name — Middle Name — Last Name — Age

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you received medical or surgical attention within the past three years? (Give full particulars)

Are all members of the Family listed above in whole and sound health to the best of your knowledge and belief?

(If Not, please explain)

IMPORTANT — EVERY QUESTION MUST BE ANSWERED

SPECIAL OFFER! Send only $1.00 for your first month's premium, during which time you will be completely insured. One application covers the whole family. If you decide to keep the policy, you can then pay the monthly rate. Don't delay—mail application today—tomorrow may be too late!

SCHEDULE OF COSTS	1 Month's Premium
ONE PERSON ONLY (Man or Woman) (under 65 years of age)	$2.00
ONE PERSON ONLY (Man or Woman) (65 to 70 years of age)	3.00
MAN AND WIFE (under 65 years of age)	4.00
MAN AND WIFE AND 1 CHILD (child under 18 years of age)	5.00
MAN AND WIFE AND 2 CHILDREN (children under 18 years of age)	6.00
MAN AND WIFE AND 3 CHILDREN (children under 18 years of age)	7.00
EITHER PARENT AND 1 CHILD (child under 18 years of age)	3.00
EITHER PARENT AND 2 CHILDREN (children under 18 years of age)	4.00
FOR EACH ADDITIONAL CHILD UNDER 18 years of age ADD	1.00

TAKE ADVANTAGE OF THIS SPECIAL OFFER —NOW!

Mail only $1.00 with your application to cover your first month's premium regardless of how many persons on this application. Remember if you're not entirely satisfied—your money will be refunded, no questions asked.

Make all checks or money orders payable to AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY

Date of this application _____ 195 ___ write your name here

Signature of applicant

F 2-10-53

Maurice E. Benson,

on behalf of the Commission, testified as follows (March 17, 1955):

[Tr. 107] * * * Q. Who has direct supervision of the claims department, and, therefore, reports to you?

A. There is a young lady by the name of Miss Endicott who has had quite a lot of experience with other companies, I think [Tr. 108] the Businessmen's Insurance Company. She came to us from there. She is well-qualified, and I feel that reliance upon her judgment is justified.

* * * * *

[Tr. 183] * * * Q. In connection with Commission's Exhibit 25, how many claims did the respondent receive from policy-holders to whom the policy had been issued?

A. We had 175 claims.

Q. One hundred seventy-five claims?

[Tr. 184] A. Yes, sir.

Q. During what period, now?

A. During the entire period, that is, down to the end of '54. I don't have any later than that.

Q. You say the end of '54? And the beginning point of that period is when?

A. When we started issuing the policy, sometime in 1953.

HEARING EXAMINER COX: February, you said?

THE WITNESS: Yes, sir.

By MR. SILLS:

Q. Is that the total number of claims received by the respondent in and out of Missouri?

A. Yes, sir.

Q. How many of those claims were disallowed?

A. Wait a minute. Let me correct that statement.

Q. All right.

A. The total number that were received is 233.

Q. Yes. What, if anything, does the 175 mean now?
A. That is the number we paid.
Q. Number you paid?
A. Yes, sir.
Q. And 58 were not paid?
A. Correct.

* * * * * *

[Tr. 186] * * * Q. Now, in connection with Commission's Exhibit 33——
A. Yes, sir.
Q. ——how many claims were filed with the respondent by policy-holders to whom that policy had been issued?
A. 5373.
Q. Yes?

HEARING EXAMINER COX: That is the answer to that question.

Now, don't encourage him to do what I have tried to stop him from doing.

MR. SILLS: Sir?

HEARING EXAMINER COX: I say, he's answered that question. I don't like for you to encourage him to do what I have been trying to stop him from doing. That is, to volunteer information.

By MR. SILLS:

Q. How many claims were filed in 1954 in connection with Commission Exhibit 33-A?
[Tr. 187] A. That was both years that I gave you.
Q. And of the 173 claims filed, how many were paid?
A. Sir?
Q. What was the number? I didn't hear you then.

HEARING EXAMINER COX: 5373 were filed. Now, the question is: how many were paid?

THE WITNESS: 2903.

* * * * * *

[Tr. 188] Q. Well, the decision as to whether or not that claim will be paid is made by whom?

A. Well, it is made in our claim department either by Miss Endicott or me.

Q. Is the decision made jointly between you and Miss Endicott?

HEARING EXAMINER COX: He told us this morning those that came in routinely she made them. If there were any questions, she took it up with him and somebody else; I don't remember.

* * * * * *

[Tr. 193] * * * Q. If I had been issued a policy, known as Commission's Exhibit 33-A to D, on July 1, 1954, and on March 1, 1955, I had been hospitalized with a cardiac condition, and I was there ten days and I filed a claim under my policy with the respondent in Kansas City——

A. Yes, sir.

Q. ——what, if anything, would you do in processing that claim?

A. We would send you the claim blanks which include a statement by your attending physician, in which we inquire of him when he first treated you for the condition for which this claim is made and how long you had had it. And if he indicates that it is the first time he treated you, then you would be paid.

Q. The doctor in his report to you will say this:

"This is the first time I ever treated Mr. Sills for a cardiac condition"?

A. That is right.

Q. "However, I have discovered that the damage has been with him for sometime, unknown to him."

MR. LAYNE: Mr. Examiner, I submit that these hypothetical questions——

[Tr. 194] HEARING EXAMINER COX: Well, let's see if this witness can answer that. We can answer it quicker than we can discuss it.

(The reporter read the question back as follows:

"Question: However, I have discovered that the damage has been with him for some time, unknown to him."

By Mr. Sills:

Q. Say, for a period of three or four years to his estimate. What, if any, consideration would you give to my claim?

A. Is there an objection to that; I didn't hear that.

Hearing Examiner Cox: Go ahead and answer it, I want to hear your answer.

The Witness: O.K.

We would write back to the doctor and find out something more about this thing and order an investigation of it, and the man, of course, who was in the hospital, naturally, with that—I mean, you say you were in the hospital, so we would get a copy of the hospital report. And if it indicated that this was the first time that anything like this happened to you, we would pay it.

Now, if you had had about three heart failures before and had not informed us of that in the application, why we would then have some just cause for questioning this claim.

[Tr. 193] Mr. Sills: I didn't ask you that, Mr. Benson.

Hearing Examiner Cox: He answered. Let's go ahead.

The Witness: I answered what you asked.

By Mr. Sills:

Q. Of the 2903 claims that you rejected that were filed under the provisions of Commission's Exhibit 33-A to D——

Hearing Examiner Cox: Let's start that one over again. 2903 was the number of claims that they paid.

Mr. Sills: Counsel's addition has improved now.

By Mr. Sills:

Q. Of the 2440 claims that you rejected that were filed by policy-holders to whom Commission's Exhibit 33-A to D had been issued, how many were rejected because of a pre-existing condition?

A. I don't know how many were rejected because of that.

Q. Well, could you generalize here briefly as possible some of the basic reasons why they were rejected?

A. Yes, sir. Some of them might have been for a pre-existing condition by reason of the fact that the insured was aware of this condition and misrepresented it in his application.

Please bear in mind that we have in this policy——

Hearing Examiner Cox: Let's forget the bearing in mind; all you are asked for is to give some of the reasons why these——

The Witness: But we have claims that were rejected——

[Tr. 196] By Mr. Sills:

Q. You must have an idea of some of the reasons that come up most frequently; let's put them in.

A. That pre-existing disease, where there was some knowledge of the insured that he had this condition; that the insured had this condition and the fact, such as I related before, that there might have been one of these, he had diabetes or cancer and he made this claim before the six-month period had expired.

And, incidentally, we have some where they came back and made a claim later after the six months where we paid on cancer and diabetes.

Also, the fact that an individual might go to a rest home for no treatment and not particularly at the prescription of a physician and that is specifically excluded from the policy.

Also the fact that, as I stated before, there are three different benefits in here. And when I say we denied them, I mean we denied the claim that he made. We did pay some benefits on some of these.

For instance, we have a medical first aid benefit of $10, but where the man wasn't under any of the other policy provisions with his claim, why he was not paid. A man might make a claim that he was riding or driving in an automobile when he was injured and it turned out he wasn't riding at all, he wasn't even in an automobile. Well, we would reject that, but we would pay him under one of these others if he was otherwise [Tr. 197] under it.

Q. Excuse me; I don't want to interrupt, but I want to get to that. Let's stay with the sickness.

A. All right.

Q. Is that about all?

A. That would be the most common one.

Q. It doesn't cover nervous or mental disorders, does it?

A. That is right, I spoke of that.

Q. Yes. And rest cures.

A. I spoke of that, too.

Q. In the light of what you said, Mr. Benson, do you think this policy provides hospitalization for any sickness?

MR. LAYNE: Mr. Examiner, I object.

HEARING EXAMINER COX: The objection will be sustained.

By MR. SILLS:

Q. I hand you Commission's Exhibit 25, and I believe you testified that of 233 claims paid, 58 were not. Could you state generally here some of the basic reasons why claims under that policy were rejected by the respondent?

A. Made a claim when he wasn't a policy-holder or that before the policy was issued or after it had lapsed for non-payment of premium, or the fact that he wasn't riding or driving in any automobile, truck or bus; because this is solely an automobile accident policy, you know.

[Tr. 198] Q. And if you are injured in an automobile accident, what form of indemnification does that provide beside the hospitalization?

A. Oh, well, if a man is confined——

Q. Just tell me from the beginning what has to happen in the order it has to happen.

A. Sir?

Q. What has to happen for him to recover anything in the order that it happens.

A. Well, if he goes to a hospital, of course, he is paid hospital benefits at the rate prescribed in the hospital——

Q. Something certainly must have happened before he went to the hospital.

A. He must have been in an automobile accident while riding or driving.

Q. Then what has to happen?

A. Well, he has to, naturally, have medical treatment. If he weren't injured at all, he wouldn't be making any claim under the policy.

Q. There are two forms of benefits provided in this policy?

A. Yes, sir.

Q. There is hospitalization?

A. That is correct.

Q. And there is what is known as a loss of time benefit?

A. As a matter of fact, there are three benefits; a death [Tr. 199] benefit, too.

Q. There is a loss of time benefit?

A. That is correct. No; where do you see loss of time? I withdraw that.

Q. I mean loss of income.

A. No; no, sir.

Q. I am talking about this, Part 3.

A. Yes, sir; that doesn't have anything to do with loss of income. He can receive a salary the whole time and still be entitled to benefits.

Q. That is total disability?

A. That is not total disability benefits; that is confinement benefits, and it is so denominated.

Q. Is this the ad that is used in connection with the advertising of this?

A. No, sir.

Q. That 9?

A. Excuse me; just a second. Yes, this is it; I am sorry.

Q. And this is what you had reference to, the "$100 a month for life——"

A. That is right.

Q. "——direct to you for life if you are injured riding or driving in any automobile"?

Is that what you have reference to: "It pays $100 a month direct——"

[Tr. 200] A. And you are confined at home under medical care or hospitalized.

Q. Right.

Now, of these claims that I have talked of that you rejected, will you state generally now the reason why they were rejected—where they were injured in an automobile accident——

A. Yes, sir.

Q. They were confined at home.

A. Yes, sir.

Q. Were those always paid?

A. Yes, sir; as far as I know, because those would come under the terms of the policy.

Q. Was the factor of time considered by the claim department from the time that the confinement began as related to the time of the accident?

A. With relation to what, sir?

Q. I direct your attention: shall immediately after the accident be wholly and continuously disabled——

A. Oh, if an insured were in such an accident and, say, two months later he decided that he was injured and went to a hospital—is that what you are referring to—we would

pay him the hospital benefits that are mentioned in there and would probably deny the confinement benefits because they were not immediately after the accidental injury.

[Tr. 201] But the hospital benefits we would pay.

Q. Supposing it were 24 hours afterward?

A. We would pay; that is immediate.

Q. Supposing while he was confined in the house, he were able to perform some kind of a duty?

A. He would still be paid.

Q. Have you ever turned down a claim where a man has been disabled as a result of an automobile accident, been confined to home and was able to perform some duty or occupation within the house?

A. No, sir; because he is still within his home.

John W. Goodin.

on behalf of respondent, testified as follows (June 7, 1956):

DIRECT EXAMINATION

I am a lawyer. I have been a lawyer since 1948. I am employed by the Missouri Division of Insurance as counsel. My duties are various. I am legal advisor for the Superintendent of Insurance and the other departments within the Division of Insurance. I consult with companies on their corporate affairs. The handling of complaints is exclusively the jurisdiction of the Legal Department and any other duties that are assigned to me by the Superintendent or referred to me by the departments within the Division. I advise in conjunction with the Attorney General of Missouri, the Superintendent in the Missouri Insurance Department, as to the statutory provisions which affect the operations of that Department. I advise with other personnel in the Missouri Insurance Department as to policies and interpretations and legal conclusions to be drawn from policies of insurance.

Whenever a problem comes up in any department within the Division that has any legal aspect whatsoever, I am called in on conference on it and am asked to render an opinion. Any complaints as to advertising conducted by companies domiciled in Missouri, that is, chartered and licensed by the State of Missouri, come to my part or section of the Missouri Insurance Department. I used the term complaints generically, and it always includes inquiries which, I suppose, are the majority of the contacts the public have with us. I do not recall any complaints received from outside of the territorial limits of the United States but we have received them from all over this country. Many of these complaints or inquiries are received directly from persons resident throughout the United States. Some of them are not. Where they are not received directly from members of the public, one other method of receiving complaints is that they are forwarded to us by the insurance supervisory officials of other states. That is a common practice among insurance superintendents or commissions in the various states.

When we receive a complaint or inquiry in the Missouri Insurance Department, first we attempt to get all of the facts surrounding the inquiry or complaint. If it is an inquiry, of course we answer the correspondent who's written in. If it is a complaint, we may contact the insurance company involved for a review of their record. We ask them to submit to us either in summary form on some occasions, by photostatic copies, or verbatim recitals of the contents of their files. We ask them to send us the information they have substantiating the position that they have taken which is being complained about. Our investigation has on occasions gone beyond merely the question of submittal of this material in writing. If at all possible we handle the thing to a conclusion through correspondence. Sometimes the correspondence becomes quite weighty and it becomes necessary to call the responsible officers within the insurance company

to the Division of Insurance for a conference on the matter.

We have contact with members of the insurance purchasing public other than through correspondence or written materials that come to the Insurance Department. We have quite a substantial walk-in trade there. There is no different treatment whatsoever accorded by us to complaints or inquiries received from persons not resident in the State of Missouri than we accord to those from persons resident in the State of Missouri.

I have been authorized by the Superintendent of Insurance in the State of Missouri to appear at this hearing. As a matter of fact he sent a letter with me to the hearing examiner and, if I may, I would like to deliver it. The letter referred to is as follows:

"STATE OF MISSOURI
Phil M. Donnelly, Governor
"DIVISION OF INSURANCE
"Department of Business And Administration"
Jefferson City

"C. Lawrence Leggett
Superintendent
June 6, 1936

"Honorable Earl Cox
Hearing Examiner
Federal Trade Commission
Washington, D. C.

"Dear Sir:

"I regret that I will be unable to appear at the FTC hearing on the complaints against Automobile Owners Safety Insurance Company and the American Life and Accident Insurance Company, because of the press of business in my office.

"However, I am sending my Counsel, Mr. John W. Goodin, and authorize him to represent me in these hearings. Mr. Goodin is familiar with the procedures fol-

lowed by my Department in the handling of complaints since these matters are handled under his direct supervision.

"Respectfully yours,

/s/ C. LAWRENCE LEGGETT,
"C. Lawrence Leggett,
Superintendent.

"CLL:mfs"

With respect to the regulation and practices of the Missouri insurance companies, the Department of Insurance of Missouri does the following functions and performs the following types of activities: We regulate them in all phases of their activities. We of course have the examiners who examine into the financial condition and the character of management, the business practices of the insurance companies operating in Missouri. We have a policy forms analyst who receives and examines and ultimately approves policies of insurance in the accident and health field. We have an actuary who deals with life insurance policies. We have a fire rater with whom the fire policies are filed. We have a workmen's compensation man. We have the agents' licensing division. We have the evaluation section, which computes the reserves on policies. In every phase of the insurance business the Missouri Division of Insurance regulates things. The examiners are full-time employees of the Department. The examination of the affairs of the Missouri insurance companies is conducted every three years. In these periodic examinations the examiners review the claim payments, claim administration, of the company under examination. They go thoroughly into all of the Division's practices, which of course includes the processing and mailing of complaints. There is at least a sampling of the claims files to determine whether a more extensive examination is necessary. I would like to correct an impression that I gave that is probably erroneous. I said that the companies are examined every three years. They

are examined at least every three years, and if occasions warrant they are examined more frequently. The Missouri Department has the power to examine an insurance company at any time when deemed necessary by the Superintendent of Insurance, including the officers. We certainly have the power to take action in cases where an examination by the examiners indicates that claims have been unfairly or improperly denied, although I think the question is moot. To my knowledge there have been no discoveries of a practice of any insurance company to unfairly deny a claim. In the event that an individual claim comes to the attention in this review by an examiner of the Department without regard to it being a practice which is unfairly in his judgment or in the judgment of the Department been unfairly denied, that is brought to the company's attention. I do not think the Department makes a definite order that the claim be paid. The usual procedure in a circumstance like that is to collect more information with regard to the claim on which they can base a determination. If there is a very serious question of fact existing, we do not consider that an unfair denial of benefits, but we have the power to order the payment of an individual claim if the proofs of loss bring it clearly within the terms of the policy. The Missouri Department takes action with respect to the interpretation of the policies. We do not permit our companies to stand on technical defenses within their policy. I do not recall an instance of having been consulted as to the meaning of policies and terms and conditions as a result of an examination, but certainly from clients coming into the office I am consulted.

I have very, very frequently reviewed in the course of my work accident and health policies of insurance companies licensed to do business in Missouri. Such examination has included policies of companies that may be domiciled elsewhere than in Missouri as long as they are licensed to do business within the State of Missouri.

It is the opinion of the Missouri Division of Insurance that we do have authority to regulate and supervise advertising used by insurance companies domiciled in Missouri. It's the opinion of the Division of Insurance that it extends to every form of advertising that can be used by a company. It is the opinion of the Division of Insurance that this power extends to advertising used by Missouri domiciled companies—that is companies chartered and licensed in Missouri—wherever disseminated by them in the United States and it's been so used. If a Missouri company has insureds in a state in which it is not licensed, we require the company to be subject to service of process within that state by the filing of a power of attorney. Automobile Owners Safety Insurance Company has on file such powers of attorney. Those are on file to the best of my knowledge in every state in which the company does business.

It's the opinion of the Missouri Division of Insurance that we in fact regulate and supervise the advertising used by the Missouri domiciled company. That is carried out as follows: there is no pre-censoring of advertising, that is we do not require the companies to get prior approval from the Division of Insurance of any advertising they propose to use. There are statutes that prohibit false and misleading advertising and if we receive a complaint or if by my men it is brought to our attention that one of our insurance companies is as a matter of fact using false and misleading advertising, we take whatever action is indicated in the premises by conference with the company seeking, tending toward the elimination of the use of the offending advertising. To date it has not been necessary to impose any penalties or sanctions against our companies. Missouri has issued a regulation or direction to Missouri companies with respect to advertising practices. A letter was sent from the Division of Insurance to the companies licensed there with relation to advertising pointing out pretty much what I just said that the advertising is the concern of the companies, that

they proceed in that manner at their own risk knowing the provisions governing their advertising. We expect them to censor their own advertising, and if they do transgress they, of course, realize that they will be subject to the penalties of action by the Division of Insurance.

Upon examining Commission's Exhibits 1 through 24, which are the advertising material used by the respondent company in the existing record, I have not received any inquiries from any members of the public with respect to that advertising material.

I have referred to the practice or policy in the Missouri Insurance Department of not permitting the Missouri companies to rest on technical defenses in denial of claims. With reference to page 3 of Commission's Exhibit 26A, which refers to the confining benefits, in the administration and regulation by the Missouri Insurance Department of the Missouri companies, the Department has the following policy with respect to the administration by the companies and payment of claims of the requirement of house confinement: that is considered a technical defense, and in many instances doctors will not go to the house to treat patients and they require patients to bundle up and come to the doctor's office. If that is the circumstance the company is not permitted to stand on that defense, but if the patient is physically able to leave his house for other purposes than medical treatment, the necessity for house confinement is a valid provision of the policy.

With reference to the provision on page 2 of the same exhibit which refers to regular medical treatment, the Department has, with respect to the administration of that sort of provision by Missouri companies, the following definite policy: we permit the companies to stand on the requirement for regular medical treatment only if there is a question as to the continuance of the condition. If there is medical evidence within the file that

the condition is a fotally disabling one and that the insured has not or will not recover from it, if the attendance, regular medical attendance, is useless and will not make him well, if the doctors can't cure him, we do not permit the companies to require the insured to spend the money for those doctor bills merely to make out a report to the insurance company.

With reference again to that portion of the same policy which appears on page 3 under Part 13 Item 2 and which refers to the submission by the insured of a medical report every 30 days, the Department of Insurance of Missouri has the following practice which they require Missouri companies to follow with respect to the administration of that provision of policies: that again is another one of the technical defenses. A company is permitted to include it in its contract to protect itself from fraudulent claims, but if the evidence within the company's claim file is sufficient to show that the condition is a continuing one it is again not necessary to have it—we don't permit them to require a regular 30 day medical report. I have read all the advertisements received in evidence as Commission's exhibits. It is the opinion of the Missouri Division of Insurance that they are not deceptive or misleading to the public.

I have read the advertisements received in evidence as Commission's exhibits. It is the opinion of the Division of Insurance under all of our procedures and practices that those documents are not misleading to the public or deceptive.

CROSS EXAMINATION

The basis for my statement with regard to the advertising of this particular company that our Department has never received any complaint about the advertising of this company is the fact that the Division of Insurance has not received complaints about the advertising I have examined in the record of the two cases here. I have

looked through our records. There has been no complaint made about the advertising.

The contact our office has with the advertising which is being disseminated by the Missouri licensed corporations comes from various sources. Perhaps an illustration will best describe just exactly what contact our office has. It frequently happens that when an insured has a complaint as to the treatment of his claim, he will write to the Division of Insurance with that complaint. Now on some of the letters we receive enclosed with his complaint will be a various number of documents. There may be premium receipts, there may be pieces of advertising material, there may be a return address cut from an envelope serving many functions, one, to identify without any possibility of error the identity of the insurance company involved. Now in the processing of claim complaints, the complaint arises first of all because the company has not paid the insured. The Insurance Department is of the opinion that he is entitled to payment for the occasion giving rise to the claim. Now in these on occasions he will say, "I was led to believe that it would be covered because of what the company told me, what I received in the mail from the company." Most frequently it is the oral representation of an agent. In those instances where the claim and the treatment of the claim has a direct bearing to the reference to advertising accompanying it through correspondence, the insurance company is contacted relative first to the handling of the claim. We like to see their file, what they have done, and what their basis for doing what they have done is, what they have within their file that justifies their action, and then if that does not resolve the complaint, it still appears that there is misrepresentation and reasonable grounds for misrepresentation, that is worked out again with correspondence or if necessary a conference with the company. If the material sent into our Division by a complainant in this instance, and parenthetically, let me say I don't recall of any particular instance where

we have received a piece of advertising material from a member of the purchasing public with a letter saying, "This led me to buy a policy of insurance; I have been misled; the advertising is wrong". I may be creating a false impression right there and I will come back to that. Remind me, I want to clear that one up. If the advertising they send in is in our opinion calculated to mislead the people, if it is misleading, if it does not fairly represent the provisions of the policy that it is supposed to describe, we will call the company in and through conference eliminate the objectionable features. It is conceivable that on some of these occasions we will be too close to the forest to see the trees ourselves. It might be in some occasions we have been convinced that we are concentrating on a particular item within the piece of advertising under question to the exclusion of the overall picture created by the entire piece of advertising. But in these discussions with the company that is worked out. If it appears, that is, if they can convince us that it is not misleading, they are told to discontinue its use. It invariably happens that they do discontinue its use.

Now back to the false impression that I may have created. On a few occasions we have had people write to the Division of Insurance and say, "I have purchased such and such a policy and it has not been as represented to me." Again most frequently it is the result of oral representation from an agent. Occasionally it happens on advertising material. They will say, "I no longer want the policy. I want my money back." In those instances we write to the insurance company, tell them that the holder of the policy has claimed misrepresentation, that they are dissatisfied with the policy, and make request for refund. In those instances where the insurance company has not been involved on the risk for any appreciable period of time, the company without question makes refund of premium and cancels the policy as of

issue date. Of course, in those instances where the policy has been in force for a period of months, the insurance company assumes, and the Division of Insurance recognizes the validity of that assumption, if the claim had arisen during that period, the policy holder would have insisted upon payments of the benefits provided by the policy. They have figured they have given the protection. Therefore we resist the refund of the premium. We have earned the premium charged for it. Unless and until it is conclusively proved that this particular insured was misled by some reason, either written advertising or oral representation, into the purchase of the policy, if it can be proved by these facts, even then they will make refund. Of course, we have approached that problem with the theory that the insured has a certain duty also with relation to his policy of insurance. It is of course a contract. They are assuming a legal relationship with an insurance company. We think it is incumbent upon them to read their policy when they receive it and at that time check it with the impressions they have concerning it. If it does not measure up at that time, clarify it. It can be done either that they get the type of policy they want or that they get a refund of their premiums. That has been rather detailed. It has been a couple of examples. I hope it has answered it.

I stated that generally or frequently the advertising material claimed of might be connected in some way with a claim which was not paid according to the policy holder's satisfaction. I have not looked at every correspondence file concerning this company. A facetious reference to the testimony of this morning, I have made a sampling which I think is a fair sampling of the correspondence in our files and based on that I would say that there has been no complaint on advertising. I am not prepared to say categorically that there has been none involving a claim which might have been based upon advertising of the company. In several of the claim

correspondence files the advertising material shows up. In some instances there has been no particular reference to the advertising material. It may have been in there merely to identify the company. It may have been in there that that is what induced them to purchase. I might amplify what I have already said. In those instances where a complaint does involve advertising, that is a claim complaint does involve advertising, and the advertising can be construed to create in the mind of the insured the impression he had as to the coverage he had, the companies are urged and cooperate in paying the claim according to the tenor of that understanding if it is not a totally outlandish, far-fetched interpretation. We have several legal means available in our office to enforce the payment of that claim. We have, of course, the insurance code. We have the general law, the general statutory law on misrepresentation. We have through procedures and practices that have been built up through the experience of the Division of Insurance over a long period of time what is generally referred to within the Division as a police power. There is some case law in the State of Missouri that also refers to the power of the Superintendent in his supervision of insurance companies. Now among the statutes within the code we have, of course, the power to examine insurance companies not only as to their financial solvency but also as to their conduct of their affairs, their management. We have a section in the statutes which permits the Superintendent of Insurance to initiate proceedings to wind up an insurance company under several things appearing to him as the result of examination or other examination. And one of them is that if the Superintendent finds that the company has violated the law, he may initiate such proceedings. Of course, the general law of misrepresentation, if that has been violated, he would have the authority to step in. Another general power given in the section relating to winding up the affairs of a company is if in his opinion, based on in-

formation coming to him, the continued operation of the insurance company would be hazardous to the public, he has the right to step in and wind up its affairs. Now the power to examine carries with it in our interpretation the power to correct any abuses in those areas in which we are empowered to examine that that examination brings to light. Otherwise, it is a useless power. It does no good to find out if you can't do anything about it. And it is a power affirmed by the Division of Insurance through its practices and procedures over a long number of years in which the companies acquiesce without raising any objection.

There have been no formal hearings called for the enforcement of any regulations dealing solely or primarily with advertising. There have been no cease or desist orders issued with relation to advertising, although it is our opinion that we have the power to do both. It has been handled through means of conference based on the theory of the Division of Insurance that our function is to administer the law for the protection of the policyholder. Now we feel that a formal citation, for instance the calling of a formal hearing, would with the attendant publicity substitute for the harm to be corrected a greater harm in that the confidence of the people in the insurance furnished by that particular company and in all insurance will be weakened by the publicity on this particular one item, and as I say we have never been forced to the issuance of a formal cease and desist order. Nor have we been forced to wind up a company if, after our conference and our recommendation to the company that it stop the practice it has been following either with relation to advertising or many of the others, if they then in the face of our recommendation persist in the action which we have found bad or—now this is prospective because it has not happened—but if it appears in our conference that their action has been willfully taken with an intention to evade or violate the law, then of course it would be not only our right but I think

our duty to step in and at least remove from the active management of the company those who have caused those bad practices to be followed. We have found the conference method a very satisfactory means of proceeding.

With regard to complaints regarding advertising being disseminated by companies domiciled outside Missouri but licensed in Missouri, we use the same method of enforcement as with reference to companies domiciled in Missouri and licensed in Missouri. It isn't always necessary for a personal conference with the officials of the out-of-state company. Sometimes it can be done through correspondence. However, we have very little difficulty in getting officials of insurance companies licensed in Missouri, wherever they might be domiciled, to come to Jefferson City.

Supposing we have a complaint with regard to a mail order insurance company which is domiciled in the State of Delaware. There are perhaps alternate procedures by which the Superintendent's office of the State of Missouri would go through to prohibit that type of advertising within the State of Missouri. If it occurs in the same fashion as it does the complaints we receive, that is the advertising as part of a claim complaint, we all either write to the person who has written to the Division of Insurance and instruct them to write to the Insurance Commissioner of the state of domicile of the offending company with regard to the claim or we within the Division of Insurance will forward the complaint with whatever enclosures might be with it to the Commissioner of Insurance in the state of domicile of the offending company.

With regard to the particular advertising involved in this proceeding, it is rather difficult to say when this advertising was first brought to my attention. Some of the individual pieces I have seen before. Some of them were brought to my attention for the first time last night on the way here to Washington. The circumstances in which I would have seen the pieces prior to coming to Washington last night were on their having been sent to

our office by members of the public. It is not always in one relation but in several relations that they were sent to our office. It is not infrequent that we will receive an inquiry concerning an insurance company, and this insurance company. The inquiry will have enclosed with it the piece of the advertising that is in evidence here. If it is an inquiry concerning the company enclosing the advertising, that does not in every instance necessarily mean that I, as a matter of course, inspect that advertising. If it is a piece of advertising that I have seen before, I pay no particular attention to it unless the inquiry itself is connected directly with the piece of advertising. It is a rather rare instance that we get a letter from a member of the public which involves simply a piece of advertising. Probably by far the vast majority are routine inquiries about various companies doing business within the State of Missouri. I can't give a definite answer as to how long it has been the policy of the Superintendent's office to direct the companies not to stand on the particular technical defenses pointed out on direct examination. It has been since I have been there, and it is my understanding—it certainly is something that I did not initiate. Whether it can be pegged to the particular section authorizing examinations or not, our usual reference to it in the Division of Insurance is that it is within the police powers of the Division of Insurance. It is true that the police powers of the Division of Insurance don't specifically set forth this ability to insist that the company not stand on its technical defenses. I can't say when that policy first started because I don't know. It has been a policy of the office since I have been there and it is something that I did not initiate. It was there when I came in. There are very few cases of disagreement between the company and the Superintendent's office as to what is a technical defense within the contract. First of all, there are very few cases of complaint on what we are calling technical defenses. Ordinarily, if the technical defense is the only defense that an insur-

ance company has to claim, it pays the claim prior to any complaint to the Division of Insurance, so we have none. If it appears on an investigation of the facts that one of these technical defenses is involved together with some other fact issues, we of course do not tell the companies not to stand on its technical defense. Our theory is that these technical defenses are protections which the insurance company is permitted to erect around itself through its contracts to protect itself from fraudulent claims. Not every claim that is sent to an insurance company is a legitimate one.

I personally engage in conversations and interviews with these people or with anyone who might come in to question the treatment of a company on particular claim because of some conception that they might have with regard to the policy due to the company's advertising. I do that in the normal and regular course. Very few of these are based upon what I term the technical defenses outlined in the policy. The majority of them are concerned with the fact that their claim has not been paid. Probably the most frequent cause of complaint in the handling of a claim is prior origination of the condition. Now whether the insured claimant complainant has from the advertising itself an understanding that the insurance policy will cover every condition that he may have had in the past or in the future or whether it is a failure on his part to understand that a condition originates at the time it first manifests itself by symptoms and not necessarily the first time he goes into the hospital to have cut out, there is a misunderstanding and in those instances frequently advertising—and I will say this, not particularly written advertising but representations of agents—are a matter of discussion.

on behalf of respondent, testified as follows (June 7, 1956):

DIRECT EXAMINATION

My name is A. A. Layne, Jr. I am an attorney. I am one of counsel for respondent in this proceeding as the General Counsel of the Association of Insurance Advertisers. The Automobile Owners Safety Insurance Company is a member of the Association of Insurance Advertisers. Automobile Owners Safety Insurance Company joined the Association of Insurance Advertisers shortly after it was created, after the company was organized, in the early part of 1953.

In accordance with the usual procedure that had been developed between myself and the members of the staff of the Bureau of what was then Cooperation and is now Consultation, I informed Mr. Millspaugh, Mr. James Millspaugh of the Federal Trade Commission who was the attorney administering the rules in behalf of the Commission, and with whom I consulted, that Automobile Owners Safety Insurance Company was a new member of the Association, and I advised Mr. Millspaugh concerning the advertising materials that they were using. In particular I advised Mr. Millspaugh that they were using advertising materials similar insofar as this case is concerned, similar to the advertising materials in issue here; and those advertising materials had previously been discussed between myself and Mr. Millspaugh as early as 1951 in connection with the Safety Drivers Insurance Company, which used this material and used a similar policy form, and which materials had been reviewed, and as to which materials Mr. Millspaugh had made suggestions for corrections, which had been made by that company.

I have available here in the room the materials that I know that I discussed with Mr. Millspaugh in 1951 and

in 1952, as well as the policy forms to which they apply. Indeed, as to that material which is similar to and identical with the material in issue in this case, I had correspondence with Mr. Millspaugh transmitting the material on July 21, 1951, and I conferred with Mr. Millspaugh on January 4, 1952 about the revision of that material, and on January 16, 1952 I submitted revised materials to Mr. Millspaugh of the Federal Trade Commission and requested the Federal Trade Commission's comments and I had some further conferences with Mr. Millspaugh concerning actuarial data in connection with the policy and the sale of the policy, and I submitted a volume of actuarial data to Mr. James Millspaugh concerning an identical policy issued by the Safety Drivers Insurance Company in October 1952. When I advised Mr. Millspaugh as to the use by Automobile Owners Insurance Company of the material as to the accident policy, Automobile Owners Accident and Hospital Policy, my files do not reflect whether or not I supplied him with copies of the material. I am confident—I am certain—that I told Mr. Millspaugh the situation. I cannot say whether I supplied the precise material to him. There was a relatively short period of time after that in which I requested Mr. Millspaugh to furnish to me any complaint or any suggestions that he had with respect to the operations of any of the members of the Association of Insurance Advertisers, including Automobile Owners.

I never received from Mr. Millspaugh any complaint or suggestions with respect to that complaint; and, indeed, Mr. Millspaugh told me shortly after the investigation, the general investigation of accident and health insurance commenced in 1954 by this Commission, that he had no complaint and no pending or outstanding matters with respect to any of the members of the Association. I never received from Mr. Millspaugh or from any other member of the staff of the Federal Trade Commission any noti-

fication of concern with respect to the advertising material prior to the issuance of this complaint.

I learned of the complaint filed against this company first by being informed by newspaper people that the complaint had been filed. I learned this from newspaper people after the complaint was issued and at the time it went into the newspapers, although I had requested on behalf of the members of the Association, including Automobile Owners, every member of the staff of the Commission and every then existing member of the Commission to give the Automobile Owners and other members of the Association an opportunity to cooperate and to correct any practices which the Commission believed were improper or believed should be eliminated.

I never received any response as to that either denying that cooperation would not be offered, or offering cooperation further, and that concludes my recollection, my certain recollection, on the matters with respect to Automobile Owners Safety Insurance Company.

CROSS EXAMINATION

I may not have made sufficiently clear whether the material now a part of the record is the identical material which I had under discussion with the members of the staff. The material which I discussed with the staff of this Commission is identical, except as to name of company, with that which is in this record relating to Commission's Exhibit 25, being policy form 1-29-53, and accompanying advertising material. My testimony was not clear; I did not intend to say that I had discussed the material in connection with the policy form identified as Exhibit 33A and related material in this proceeding.

The Examiner here ruled that official notice would be taken of matters published in the Federal Register pertaining to the Trade Practice Rules for the Advertising and Sales Promotion of Mail Order Insurance. Official

notice will also be taken of the official pronouncement of the Commission with respect to Trade Practice Conferences for accident and health advertising that have appeared in the Federal Register.

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(219)

[Caption omitted]

Notice to Produce

To: Francis B. Mayer, Esquire
Philip Melangton, Esquire,
Counsel Supporting the Complaint

Please take notice that you are hereby requested to produce, at the hearing for the taking of testimony on behalf of respondents in the above case, now scheduled for June 7, 1956, the originals or duplicate originals of the following documents, which respondent believes to be in the possession of the Federal Trade Commission:

(1) Letter dated June 5, 1951, from James W. Millspaugh, Attorney, Rule Administration Division, to American Automobile Owners Safety Ass'n;

(2) Letter dated June 11, 1951, from Harry J. Goulding, Vice President, American Automobile Owners Safety Ass'n to James W. Millspaugh;

(3) Letter dated July 21, 1951, from A. Alvis Layne, Jr. to James W. Millspaugh;

(4) Letter dated January 16, 1952, from A. Alvis Layne, Jr., to James W. Millspaugh;

(220)

(5) Letter dated October 15, 1952, from A. Alvis Layne, Jr. to James W. Millspaugh.

If you fail to produce as required, secondary evidence of the contents of the foregoing documents may be used against you.

s/ A. Alvis Layne, Jr.,
A. Alvis Layne, Jr.

s/ T. S. L. Perlman.
T. S. L. Perlman,
Attorneys for Respondent,
952 Pennsylvania Building,
Washington 4, D. C.

June 4, 1956

Colloquy Between Hearing Examiner and Counsel Relative to Notice to Produce, Motion to Produce, and Disposition of Motion

[Tr. 430] * * * Mr. Layne: We have only one further matter in that proceeding. That is, with respect to this respondent's prior course of conduct at the F.T.C. There was served upon counsel representing the complaint on Monday of this week, a notice to produce certain documents in the possession of the Federal Trade Commission.

I wonder if counsel supporting the complaint can now tell us whether or not they will produce pursuant to that notice.

Mr. Mayer: As I do not see any particular provision for this type of document within the rules and practices of the Commission, Mr. Examiner, I nevertheless formally decline Mr. Layne's request to produce these documents. [Tr. 431] Hearing Examiner Cox: The notice to produce is a matter of record, is it not, that notice is?

Mr. Layne: Yes, sir. It was filed and served.

Hearing Examiner Cox: Filed on the 4th of June, according to the copy I have.

Mr. Layne: Yes, sir.

Mr. Examiner, I am in a little bit of a quandary here at this juncture. In view of what we all know to be the prior history of these various proceedings, in order that

the record might be quite clear, I will ask the Examiner if he will instruct counsel supporting the complaint to produce those documents.

HEARING EXAMINER COX: Well, according to prior ruling of the Commission on a similar request, I understood the Commission to rule that these matters were confidential, being part of the investigational file of the Commission and that in the other cases the Commission declined to order the production of these documents.

So my ordering counsel in support of the complaint to produce them now would be contradictory to the past ruling of the Commission.

MR. MAYER: May I be heard, sir? I do not know whether this will be particularly helpful. I imagine Mr. Layne is attempting to use the notice to produce as it is generally used. And his concluding paragraph is if we fail [Tr. 432] to produce his request, then the secondary evidence may be used. I wish to inform him that we will make no objection whatever to the admission of those particular documents on the basis of genuiness [sic] or authenticity.

MR. LAYNE: I would like to request now that the counsel supporting the complaint be instructed to produce on behalf of the Commission all copies of advertisements identified in this proceeding as having been used by Automobile Owners Safety Insurance Company and policies issued by them which were supplied to the Bureau of Consultation or Bureau of Cooperation, or Bureau of Trade Practice Conference of this Commission.

MR. MAYER: Mr. Examiner, I am not the custodian of those documents. If Mr. Layne supplied them to any portion of this Commission for any purposes, in my opinion if he makes proper application to the Secretary of this Commission for their return they will be returned to him.

But I am not the official custodian of any of the documents that he requests.

MR. LAYNE: I thought we were just getting these matters formally out of the way.

MR. MAYER: If the intention is to make use of secondary evidence, as I said before, I have no objection on the basis of secondary evidence to the use of documents which were submitted or requested to be produced, on the [Tr. 433] basis that they are not authentic and genuine.

MR. LAYNE: I was trying—Mr. Mayer—perhaps there has been a change.

HEARING EXAMINER COX: The record may show, Mr. Layne, that a similar request was made by counsel for the respondent in Postal case, was it not?

MR. LAYNE: Yes. And in the American Life and Accident case.

HEARING EXAMINER COX: And in the American Life and Accident case——

MR. LAYNE: Docket No. 6238 and 6276

Postal Life and Casualty is Docket 6276 and American Life is 6238.

HEARING EXAMINER COX: And that that request was denied by the Commission, and the Hearing Examiner will assume that the same result would take place if the matter went to the Commission in this proceeding.

IN THE UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15830

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,
Petitioner

v.

FEDERAL TRADE COMMISSION

Petition for Review of an Order of the Federal Trade Commission

Automobile Owners Safety Insurance Company, a corporation, by its attorneys, presents this its petition to review and set aside an order of the Federal Trade Commission, entered in the *Matter of Automobile Owners*

Safety Insurance Company, Federal Trade Commission Docket No. 6239, on April 26, 1957 and served on petitioner on May 3, 1957.

NATURE OF PROCEEDINGS AS TO WHICH REVIEW IS SOUGHT

The proceedings as to which review is sought arose out of a complaint for an order to cease and desist and a notice of hearing, issued by the Federal Trade Commission pursuant to Section 5(b) of the Federal Trade Commission Act (38 Stat. 719, as amended, 15 U.S.C. 45(b)) on October 14, 1954 and served on petitioner on October 17, 1954. The complaint alleged that petitioner was engaging in unfair or deceptive acts or practices in interstate commerce in the sale of certain policies of accident and sickness insurance, in alleged violation of Section 5(a) of the Federal Trade Commission Act. The allegedly unfair or deceptive acts or practices consisted of the mailing of certain written advertisements to various members of the public, which advertisements were alleged to contain statements misrepresenting the terms of the insurance policies. The proceeding was one of about 41 such proceedings brought by the Commission, alleging similar practices by accident and health insurance companies.

In due course petitioner appeared and showed cause why an order to cease and desist should not be entered by the Commission. Hearings were held before a hearing examiner of the Commission, in which testimony was taken and reduced to writing and exhibits were received in evidence. Upon such hearing, the Commission's hearing examiner was of opinion that no order to cease and desist should be entered; he therefore entered an initial decision, in writing, dismissing the complaint. Thereafter, the Commission, reversing the order of its examiner, made a report in writing stating its findings as to the facts, to the effect that petitioner's said acts or practices had been misleading or deceptive, and caused to be

served on petitioner a final order to cease and desist from using advertisements containing certain described language. Review is sought of that order.

Jurisdiction and Venue

The Commission's order to cease and desist was served on petitioner on May 3, 1957. The jurisdiction of this Court is invoked under Section 5(c) of the Federal Trade Commission Act (38 Stat. 719, as amended, 15 U.S.C. 45(c)).

Petitioner resides and carries on business within the Eighth Judicial Circuit, in that petitioner is a corporation organized and existing under the laws of Missouri, having its principal place of business at Kansas City, Missouri. The acts and practices in question were used within the Eighth Circuit, in that the advertisements alleged to contain the alleged misrepresentations were written and the policies sold as a result of such advertising were issued within the State of Missouri.

Grounds on Which Relief is Sought

The grounds upon which relief is sought center around three kinds of errors committed by the Commission, as follows: (1) errors involved in the Commission's refusal to give effect to or to permit petitioner to rely on the Commission's own substantive regulations, known as Trade Practice Rules, which purported to specify the proper content of advertisements used in petitioner's industry and with which petitioner was at all relevant times in full compliance. (2) Errors involved in the holding that petitioner's voluntary discontinuance, before commencement of the proceedings below, of the practices complained of did not warrant dismissal of the proceeding (under the settled doctrine that such an "abandonment" warrants dismissal of the proceeding where there is little likelihood that the abandoned practices will be resumed), because of the Commission's view, unsupported by evidence, that there is likelihood of the resumption

of the practices. (3) Errors in holding, contrary to the evidence, that petitioner's advertising, both before and after petitioner's institution of the practice of setting forth the policy in full, was misleading and deceptive. A brief statement of the circumstances of these holdings may clarify the nature of the errors. Thereafter the errors will be specified in detail.

I. The Commission's Errors in Holding Its Own Controlling Regulations Irrelevant

1. For many years the Commission has had a practice of promulgating, at the instance of members of an industry or otherwise, so-called Trade Practice Rules. These are in the nature of substantive rules or regulations, promulgated in the exercise of the Commission's implied powers under the Federal Trade Commission Act, to define various unfair methods of competition or unfair and deceptive acts or practices in the terms and circumstances of the particular industry, "for"—in the Commission's words—"the guidance of businessmen."[1]

2. Such Trade Practice Rules are enacted pursuant to procedures set forth in the Commission's Rules of Practice, which conform closely with the procedures for rule-making set forth in Section 4 of the Administrative Procedure Act (60 Stat. 238, 5 U.S.C. 1003). The procedures include provision for petitions by the public, notice and public hearings on proposed rules, and publication in the Federal Register of the rules adopted.

3. Petitioner is a member of a group which in 1948 applied to the Commission for such rules for petitioner's industry, known as the mail order insurance industry. In due course, after the specified procedures, such rules were promulgated and published, on February 3, 1950 (15 Fed. Reg. 599). They remained in effect until their

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[1] Section 2.21, Rules of Practice and Procedure, Federal Trade Commission.

repeal on August 22, 1956 (21 Fed. Reg. 6332), at which time the proceedings below had been pending for almost two years. These regulations defined unfair and deceptive practices in insurance advertising of the kind used by petitioner. By implication, advertisements which complied with the rules were free from deception in the respects dealt with by the rules.

4. Pursuant to established practice, members of the industry, including petitioner, signified their adherence to these Rules. Also following regular practice, the Commission undertook, through its staff, the duty of examining advertisements, submitted to it by adherents to the Rules, with a view to advising the latter as to their compliance with the Rules. Certain of petitioner's advertisements—including some of the very advertisements on which the present order is based—were thus examined; suggestions were made by the Commission for revisions in certain respects; the suggestions were adopted; and the advertisements were pronounced unobjectionable by the Commission.

5. The practice of cooperative submittal and approval was being carried on actively by the parties, when, without notice or warning, without repeal or amendment of the regulations, without any prior disapproval of petitioner's advertising, and without any complaint against petitioner from any public source, the Commission instituted the proceeding of which review is now sought, alleging deception in the very advertisements which it had previously approved.

6. In the course of the proceedings below respondent sought, by appropriate procedures, to obtain from the Commission's documentary files and by testimony of the Commission's personnel, evidence showing that petitioner's advertising was and had been in compliance with the Trade Practice Rules. The Commission, by an interlocutory order, refused petitioner access to such evidence, holding the

compliance of petitioner's advertising with the Rules to be irrelevant. Thereafter the hearing examiner rejected, in reliance on such order, all offers by petitioner of evidence that the advertising statements complained of were proper under the Trade Practice Rules.

7. Petitioner submits that the Commission's holding and the rulings thereunder were erroneous in that the Trade Practice Rules are substantive regulations, binding on the Commission as well as on the petitioner, which may not be altered or amended by the Commission, except in accordance with its rule-making procedures, and, even then, not retroactively. If petitioner's advertising was, under these Rules, not unfair or deceptive, the Commission could not validly find to the contrary. Therefore, deprivation of petitioner's opportunity to prove compliance with the regulations requires reversal.

II. Errors in Holding That the Facts Did Not Amount to Abandonment

1. The Commission and the Courts of Appeals recognize a doctrine of law to the effect that, although a party has engaged in practices violative of the Federal Trade Commission Act, nevertheless the violation does not warrant the issuance of a cease and desist order if the party has voluntarily abandoned the practices in circumstances which indicate that there is no likelihood of its resuming them after dismissal of the proceeding.

2. Petitioner presented evidence below that it contends demonstrated such a voluntary abandonment of the practices complained of. Petitioner also presented evidence of its history of cooperative dealing with the Commission under the Trade Practice Rules, as described in Part I above, contending that this evidence tended to establish its propensity to abide by whatever the Commission might state the law to require, without the need to be bound by a cease and desist order. On the basis of this evidence petitioner sought dismissal under the doctrine stated above.

3. The Commission, in its decision, acknowledged the doctrine and conceded that petitioner had stopped using the advertisements complained of, but held that dismissal was not warranted because petitioner had not proved that the practices had been finally and definitely discontinued. This conclusion was based on the Commission's alleged consideration of all the circumstances; but, as the Commission indicated, the only relevant circumstances of which the record contains evidence, are the circumstances surrounding petitioner's history of cooperation with the Commission in bringing its advertising into conformity with the Trade Practice Rules. These circumstances, as the Commission indicated, support petitioner's position that the future conduct to be reasonably expected of petitioner is likewise cooperative. Petitioner submits that the Commission's contrary conclusion was wholly arbitrary and without basis in the evidence, was an abuse of discretion, and was therefore erroneous.

III. Errors on the Merits

1. Finally, the Commission predicated its underlying finding of the unlawful character of the prior practices on nothing more than its own reading of the advertisements and the policies. This reading resulted in its attributing to the advertisements the power to create in the minds of the public "impressions" of the terms of the policies contrary to the actual terms, although such "impressions" in no instance comprised the literal import of the questioned advertisements. It also resulted in the Commission's holding such impressions contrary to the terms of the policies as interpreted by the Commission, despite uncontradicted evidence in the record that in actual practice the policy is interpreted and is required by state insurance officials to be interpreted otherwise. The Commission's findings were supported by no evidence as to the public's actual or probable "impressions" of the advertising, no evidence of dissatisfaction on the part of the public with the advertising, and no evidence of the

actual interpretation of the policies, and were made in the face of evidence to the contrary presented by petitioner.

2. The terms and circumstances of the particular findings cannot readily be set forth without consideration of the record as a whole, but petitioner submits that the Commission's findings in this respect are not supported by substantial evidence on the whole record.

IV. Specification of Errors to Be Urged

In the light of the foregoing, the errors may be specified as follows:

1. The Commission erred in failing to hold that petitioner's compliance with the Trade Practice Rules required dismissal.

2. The Commission erred in excluding evidence that the advertisements complained of were in compliance with the Trade Practice Rules.

3. The Commission erred in failing to hold as a matter of law that the petitioner's voluntary abandonment of its allegedly unlawful practices required dismissal.

4. The Commission erred in finding as a fact that petitioner was not unlikely to resume its former practices.

5. The Commission abused its discretion in failing to dismiss the proceeding under the doctrine of "abandonment".

6. The Commission erred in failing to hold as a matter of law that petitioner's practices were neither unfair nor deceptive.

7. The Commission erred in finding as a fact that petitioner's practices were unfair and deceptive.

8. The Commission erred in issuing a cease and desist order against respondent.

Relief Prayed

For the foregoing reasons, petitioner prays that the Commission's order to cease and desist should be reversed and set aside. If the Court is of the view that the Commission erred as alleged in its holdings on the issue of whether petitioner's practices were unfair or deceptive or that the Commission erred as alleged with reference to the doctrine of abandonment, judgment of dismissal should be entered. If the Court is of the view that the Commission erred as alleged with respect to petitioner's compliance with the Trade Practice Rules, judgment of dismissal should be entered, or, in the alternative, the proceeding should be remanded to the Commission with directions to make available to petitioner and to permit petitioner to present evidence of such compliance.

Respectfully submitted,

A. Alvis Layne, Jr.
T. S. L. Perlman
Pennsylvania Building
Washington 4, D. C.

Maurice E. Benson
412 Commerce Building
Kansas City, Missouri
Attorneys for Petitioner

[Jurat omitted]

[Caption omitted]

Docket Entries

Respondents: Automobile Owners Safety Insurance Company. Complaint Served: 10-20-54. Answer Filed: 12-3-54. Initial Decision Served: 10-18-56. Commission Decision Served: 5-3-57.

History

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12-3-54 Hearing Examiner's order receiving and incorporating into the record answer and motions by respondent.
Served:

A. Alvis Layne, Jr.—12-7-54

12-3-54 Motion by respondent to dismiss complaint, or, in the alternative that complaint be dismissed and matter referred to Bureau of Consultation of the Commission for disposition under cooperative procedures of that Bureau.

(contained in answer filed 12-3-54)

12-13-54 Hearing Examiner's order denying motion by respondent to dismiss complaint and postponing initial hearing set for December 13, 1954, to January 24, 1955, at 10 a. m., Washington, D. C.
Served:

A. Alvis Layne, Jr.—12-15-54
Wendell Berge—12-15-54

* * * * * * * * * * *

6-4-56 Notice by respondent requesting counsel supporting complaint to produce originals or duplicate originals of documents.

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10-4-56 Hearing Examiner's initial decision and order dismissing complaint, without prejudice.
Served:

CSC (Melangton)--10-17-56
CSC (Mayer)—10-17-56
A. Alvis Layne, Jr.--10-18-56

10-24-56 Notice of appeal by counsel supporting complaint from hearing examiner's initial decision:
Mailed:

Automobile Owners Safety Insurance Company--
A. Alvis Layne—

4-26-57 Findings as to the facts, Order to cease and desist, and order to file report of compliance.
Opinion—Commission—attached.
Opinion—Tait—attached.
Served:

A. Alvis Layne, Jr.—

7-2-57 Petition to review—(filed by Automobile Owners Safety Insurance Company)
(for Court record, see Sheet 3)

The Opinion of the Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15,830

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,
Petitioner,

vs.

FEDERAL TRADE COMMISSION, *Respondent*.

Petition to Review Decision of the Federal Trade Commission

[May 16, 1938.]

A. ALVIS LAYNE, JR. (T. S. L. PEARMAN and MAURICE E. BENSON were with him on the brief) for Petitioner.

E. K. EDMISS, Attorney, Federal Trade Commission (ERNEST W. KUTNER, General Counsel, JAMES E. CORKEY, Assistant General Counsel and EDWIN S. ROCKEFELLER, Attorney, Federal Trade Commission, were on the brief) for Respondent.

Before GARDNER, *Chief Judge*, and JOHNSEN, *Circuit Judge*, and DONOVAN, *District Judge*.

GARDNER, Chief Judge.

This is a companion case to *American Life and Accident Insurance Company v. Federal Trade Commission*, No. 15,828, 8 Cir., ... F.2d ..., in which we have already determined the issues. As in *American Life and Accident Insurance Company v. Federal Trade Commission*, *supra*, this proceeding was instituted by the Federal Trade Commission under Section 5 of the Federal Trade Commission

Act, 15 U.S.C. Section 41 et seq., charging that petitioner had been using unfair and deceptive acts or practices in interstate commerce and seeking an order directing petitioner to cease and desist therefrom. The charge was based on petitioner's use of certain allegedly misleading and deceptive representations in the advertising for sale of two policies of sickness and accident insurance.

Petitioner by its answer put in issue all the material allegations of the complaint. A hearing on the issues joined by the pleadings was had before a trial examiner who made findings sustaining the allegations of the complaint as to the deceptiveness of petitioner's advertising representations but found that the acts and practices complained of had been discontinued, and that it was reasonable to assume they would not be resumed, and he therefore entered a provisional order dismissing the complaint. Counsel supporting the complaint appealed to the Commission from that part of the provisional order dismissing the complaint. Petitioner did not appeal from the initial decision finding the acts and practices complained of unfair, misleading and deceptive. On the hearing before the Commission petitioner specifically declared:

> "Respondent has not insisted upon its denials of jurisdiction or of violation. It has filed no appeal from the Examiner's findings of jurisdiction or of violation; and if further assurance is needed, it is now prepared to concede it has violated the law and that the Commission has jurisdiction."

The Commission approved the findings of the trial examiner finding that petitioner had engaged in deceptive advertising acts and practices as alleged in the complaint, and specifically found that its representations as to indemnification provided by its policies were false, misleading and deceptive. The Commission, however, refused to adopt the examiner's finding that the unfair and deceptive practices complained of had been discontinued

and that there was no reasonable ground for believing they would be resumed in the future. The Commission thereupon entered the order to cease and desist which is now before us for review.

Petitioner seeks reversal of the decision of the Commission and seeks to set aside its cease and desist order on the following grounds: (1) The Commission erred in refusing to consider its own trade practice rules and in refusing to produce or admit evidence of petitioner's compliance with the trade practice rules; (2) the Commission erred in setting aside the examiner's finding that there is no reasonable likelihood of petitioner's resuming use of its abandoned advertising, and (3) the Commission erred in finding the advertising misleading and deceptive.

As to ground number one, it need only be said that this contention cannot be sustained for the reasons set out in our opinion in the companion case, *American Life and Accident Insurance Company* v. *Federal Trade Commission*, supra. It cannot be consistently urged that there was any prejudicial error in rejecting certain proffered testimony going to the question that the petitioner, before using its advertising material, had consulted certain lawyers of the Commission's staff. The charge was not that the trade practice rules had been violated, but that certain provisions of the Federal Trade Commission Act had been violated. Having admitted the violation of this Act, as found by the examiner, the so-called excluded evidence could have no real bearing on the issues involved in the case.

In our view the only substantial question is whether or not the Commission erred in refusing to dismiss the complaint on the ground that the unlawful, misleading and deceptive practices had not only been abandoned but that there was no reasonable likelihood of their being resumed. It is argued that the Commission found that the unlawful practices

which had been established by the evidence and admission of the petitioner, had in fact been abandoned some three months prior to the institution of the present proceeding. We think this is not quite true. In discussing this question the Commission among other things found:

> "Respondent stopped using the particular policy forms here involved in the very shadow of Commission action and after the Commission had instituted a general investigation of advertising practices in the accident and health insurance industry. There has been no showing of any discontinuance of the type of insurance coverage contained in such policy forms. Considering all the circumstances, we must conclude that there is little in this record to suggest that the unlawful practices have been finally and definitely discontinued. Conversely, there is no assurance that practices which have not been surely stopped will not be resumed in the future."

This court has held that even where the unlawful practice has been abandoned the Commission is not obligated to assume that such practices will not be resumed. *Chamber of Commerce of Minneapolis* v. *Federal Trade Commission*, 8 Cir., 43 F.2d 673; *Arkansas Wholesale Grocers' Association* v. *Federal Trade Commission*, 8 Cir., 18 F.2d 866; *Federal Trade Commission* v. *Wallace*, 8 Cir., 75 F.2d 733. In *Chamber of Commerce of Minneapolis* v. *Federal Trade Commission*, supra, there had been an abandonment of the deceptive practices some years before the complaint had been filed with the Commission. The court nevertheless sustained a cease and desist order in its substantial parts and in doing so said:

> "It is contended that the objectionable publications ceased four years before the complaint issued and there is no intention to renew them, therefore, there was no basis for the order as to such. It may be that the immediate inciting cause for the publications has vanished or is inactive. However, this is not of itself sufficient to vacate that part of the order although it

might be reason for refusing, without prejudice, an application for the enforcement thereof at this time."

In *Arkansas Wholesale Grocers' Association v. Federal Trade Commission*, supra, this court again had occasion to consider the argument that a cease and desist order entered by the Commission should not be enforced because the inhibited practices had been discontinued and in the course of the opinion said:

> "It is urged that many or all of the practices which formed the basis of the findings and order of the commission had taken place and had been discontinued some time prior to the filing of the complaint. This, if true, would not affect the jurisdiction of the commission nor the propriety of the order made, since the commission is not obliged to assume that such practices will not be resumed."

In *Federal Trade Commission v. Wallace*, supra, we reaffirmed the doctrine of our prior decisions as to the insufficiency of an alleged abandonment of the unlawful practice as a bar to the entry of a cease and desist order. It is there said:

> "Abandonment will not be presumed and, even though pleaded and presently effective, is no bar to the entry of an enforcement order. A bill not specifically denied is a basis for a decree limited to future acts. There is no guaranty that the acts complained of will not be renewed if the relief prayed is denied. *Arkansas Wholesale Grocers' Association v. Federal Trade Commission*, supra; *Swift & Co. v. United States*, 276 U.S. 311, 48 S. Ct. 311, 72 L. Ed. 587; *Local 167, International Brotherhood of Teamsters, etc. v. United States*, 291 U.S. 293, 78 L. Ed. 804."

In the instant case, as in *American Life and Accident Insurance Company v. Federal Trade Commission*, supra, petitioner admitted the correctness of the findings of the

examiner as to the violations alleged, and it did not appeal to the Commission from those findings. The petitioner ceased the practices only after the Commission had instituted a general investigation of the advertising practices in the accident and health insurance industry. On the whole record the Commission was not satisfied that the unlawful practices had been finally and definitely discontinued and would not be resumed in the future. The Commission is a fact-finding agency and we cannot say that this was not a permissible conclusion based upon all the facts, the surrounding circumstances and in inferences that might reasonably be drawn therefrom.

Notwithstanding the fact that petitioner did not file a cross-appeal, presenting to the Commission the question of the sufficiency of the evidence to sustain the examiner's findings that it had committed the misleading and deceptive practices alleged in the complaint, and notwithstanding the fact that during the hearing before the Commission it specifically admitted that it had violated the law in the particulars found by the examiner, it now contends that the Commission erred in finding its advertising misleading and deceptive. We think the petitioner, in view of this record, cannot now be heard to urge this alleged error.

We have considered all the other contentions of petitioner and are of the view that they are without merit. The cease and desist order is affirmed and a decree of enforcement will be entered in due course.

JOHNSEN, Circuit Judge, dissents, for the reasons stated by him in the companion case hereto, No. 15,828, *American Life & Accident Insurance Co. vs. Federal Trade Commission*.

A true copy.

Attest:

Clerk, U. S. Court of Appeals, Eighth Circuit.

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT.
No. 13830

Automobile Owners Safety Insurance Company,
Petitioner,

v.

Federal Trade Commission,
Respondent.

FINAL DECREE ENFORCING ORDER TO
CEASE AND DESIST

Automobile Owners Safety Insurance Company, a corporation, petitioner herein, having filed in this Court on July 2, 1957, a petition to review and set aside an order to cease and desist issued against it on April 26, 1957, by the Federal Trade Commission, respondent herein, in a proceeding before it entitled "IN THE MATTER OF AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY, a corporation, Docket No. 6239"; and a copy of said petition having been served upon respondent; and respondent having thereafter certified and filed herein, as required by the Federal Trade Commission Act, a transcript of the entire record in said proceedings and the matter having been heard by this Court on briefs and oral argument on March 5, 1958; and this Court having thereafter fully considered the cause and having rendered its decision on May 16, 1958, affirming said order;

NOW, THEREFORE, IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the aforesaid petition to review be, and it hereby is, dismissed, that the aforesaid order to cease and desist, as heretofore affirmed, be, and it hereby is enforced, and that petitioner be, and it hereby is, commanded to obey said order and to comply therewith; and

IT IS HEREBY FURTHER ORDERED, ADJUDGED AND DECREED that within sixty days from date of issuance of certified copy of this decree to the Federal Trade Commission the petitioner file with the Federal Trade Commission a report in writing, setting forth in detail the manner and form in which it has complied with said order to cease

and desist.

Without prejudice to the right of the United States, as provided in Section 5(1) of the Federal Trade Commission Act, to prosecute suits to recover civil penalties for violation of the aforesaid order to cease and desist, hereby enforced, and without prejudice to the right of the Federal Trade Commission to institute and maintain contempt proceedings for violation of this decree, this Court retains jurisdiction of this cause to enter such further orders herein from time to time as may become necessary effectively to enforce compliance in every respect with this decree and to prevent evasion thereof.

June 13, 1958

IN THE

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15830

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,
Petitioner

v.

FEDERAL TRADE COMMISSION, *Respondent*

On Petition for Review of a Decision of the Federal Trade Commission

PETITION FOR REHEARING

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FILED
JUN - 4 1938
ROBERT C. TUCKER
CLERK

PRESS OF BYRON S. ADAMS, WASHINGTON, D. C.

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IN THE

United States Court of Appeals

FOR THE EIGHTH CIRCUIT

No. 15830

AUTOMOBILE OWNERS SAFETY INSURANCE COMPANY,
Petitioner

v.

FEDERAL TRADE COMMISSION, *Respondent*

On Petition for Review of a Decision of the Federal Trade Commission

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PETITION FOR REHEARING

Automobile Owners Safety Insurance Company files this petition for rehearing to direct the attention of the Court to matters of fact and law which petitioner believes the Court overlooked and which petitioner believes are controlling.

PETITIONER DID NOT CONCEDE THAT IT VIOLATED THE LAW OR THAT THE COMMISSION HAD JURISDICTION

The Court's holding on the first assignment of error appears to rest in part upon the proposition that, "Having admitted the violation of this Act, as found by the examiner, the so-called excluded evidence could have no real bearing on the issues involved in this case." (Slip Opinion, p. 3). The statement seems to rest upon the assertion (1) that petitioner failed to cross-appeal to the Commission from the Examiner's order and (2) that petitioner's answering brief on appeal to the Commission constituted an admission that the Examiner's findings of deception and jurisdiction were correct. This overlooks several important matters of fact and law.

1. It Was Agreed by Both Parties That the Commission's Ruling on Petitioner's Trade Practice Evidence Defense Would Have Been Adverse to Petitioner.

This case was tried at the same time as two prior cases presenting similar questions, *In the Matter of Postal Life and Casualty Insurance Company*, FTC Docket No. 6276, and *In the Matter of American Life and Accident Insurance Co.*, FTC Docket No. 6238 (now pending on petition for rehearing, *American Life and Accident Insurance Co. v. FTC*, No. 15828, this Court). In both the Commission had expressly ruled irrelevant to any issue in the proceedings those companies' compliance with the same Trade Practice Rules here in issue. In the *American Life and Accident Insurance Company* case, counsel for both parties and the Hearing Examiner were the same as counsel and the Hearing Examiner in the instant case. In the *Postal Life & Casualty Ins. Co.* case, the same Examiner presided and one of counsel for the company was one of present counsel for petitioner. Portions of the instant case and the *American Life and Accident Insurance Co.* case were tried on a consolidated record. To save the time and ex-

pense of the present petitioner's futilely raising and appealing to the Commission questions of the admissibility of specific items of evidence, the net tendency of which was to prove the compliance of both petitioners with the same Trade Practice Rules, the Hearing Examiner, in the presence of both parties, and without objection, ruled in effect that if petitioner had sought to introduce evidence of the Trade Practice Rules or its compliance with them, the Examiner would have excluded the evidence on the authority of its *Postal* and *American Life and Accident* decisions, and that if petitioner had appealed the rulings to the Commission, the Commission would have affirmed on the same grounds. In the circumstances, a further appeal or assertion of its position by petitioner would have been futile.

2. The Court Has Misconstrued Petitioner's Statement Before the Commission

The passage quoted by the Court (Slip Opinion, p. 2) from petitioner's answering brief on appeal before the Commission was inserted pursuant to a requirement of the Commission as a formal prerequisite to alleging the defense of abandonment. The concession was made for the limited purpose of permitting consideration of the issue raised by that defense, and was conditional upon the Commission's accepting that defense. It was not relied upon by the Commission, and should not be read as a waiver of petitioner's contentions on other issues in the case, when the abandonment issue was held to be unavailable to petitioner.

After the Commission's preliminary rulings rejecting petitioner's evidence and defenses, petitioner's only remaining available defense was that based on the abandonment (discontinuance) of its allegedly deceptive practices. Such a defense is in effect an assertion that even if petitioner had violated the law, no order should be entered against it. The Examiner found in petitioner's favor on this issue. The Commission's counsel supporting the com-

plaint appealed from this finding. The Commission had recently held, in accordance with a position frequently put forward by it, that the defense of abandonment could not be successfully urged by a respondent who continued to contest the Commission's jurisdiction or to deny the unlawfulness of the respondent's acts. *National Casualty Co.*, Federal Trade Commission Docket No. 6311 (decided May 25, 1956), reversed on other grounds, 245 F. 2d 883 (C.A. 6), now pending on writ of certiorari, 355 U.S. 867. The Commission stated the requirements of waiver necessary to argue abandonment in *Massachusetts Bonding and Insurance Co.*, Federal Trade Commission Docket No. 6447 (decided November 7, 1956), as follows:

> "One of the circumstances which, to the Commission, seems significant is the respondent's insistence throughout this proceeding that the Commission is without jurisdiction over any of the respondent's activities. Another is the respondent's contention, which it has maintained with equal vigor, that none of its advertising statements or representations, including those referred to in the complaint, were in any respect false or misleading. Thus, the respondent is in the position of having agreed to comply with trade practice rules which it believes are without force and effect, and to refrain from the use of advertising representations which it believes it has a legal right to make. In these circumstances the Commission cannot find that the public interest would be served by a termination of this proceeding, and, accordingly, the respondent's motion must be denied."

In the brief on appeal from the Examiner's order in this case, counsel for the Commission stated (Tr. 332):

> "It would seem that the hearing examiner has dismissed the complaint indirectly for reasons which he could not use directly. There can be no question of estoppel of the Federal Trade Commission in this proceeding and therefore the point of whether respondent was or was not complying with the 1950 rules will not be belabored. The only question is whether the dis-

> continuance of certain pieces of advertising obviates the necessity for a cease and desist order. *The Commission has been afforded no basis for a conclusion that the practices will not be resumed in the future. Respondent has continually denied that the Federal Trade Commission has any jurisdiction to regulate its advertising. Respondent has also denied that any of its advertising is or ever was false, misleading and deceptive.*" (Emphasis added.)

Petitioner accordingly made the statement quoted by the Court for the limited purpose of bringing before the Commission the abandonment issue. By it petitioner was saying to the Commission in effect, "If you hold in our favor on this issue, we will no longer deny that we have acted unlawfully or that you have jurisdiction," as one would offer to abandon claims or defenses in connection with an offer in compromise. When the Commission rejected the offer, petitioner's concession was rejected with it.

The Court has extended the effect of the offer or conditional concession to other issues as though it were unconditional. Such a treatment amounts to a requirement that a respondent before the Commission give up valid defenses, including defenses going to the Commission's jurisdiction, as a price for asserting another, not inconsistent, valid defense. This is analogous to requiring a defendant to waive his right to appeal as a condition precedent to presenting a defense and is therefore unlawful. *Green* v. *United States*, 355 U.S. 184, 193-194. The Court's interpretation gives petitioner's statement in this contested case an effect broader than is ordinarily given in the Commission to a respondent's consent to the entry of a consent cease and desist order.[1]

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[1] § 3.25(b) of the Rules of Practice and Procedure, relating to consent orders, provides:

> "The agreement shall also contain a waiver by the respondents of any right to challenge or contest the validity of the order entered in accord-

The Commission itself did not give so broad an interpretation to petitioner's alleged concession. The Commission's opinion analyzes the evidence and considers the question of the lawfulness of petitioner's acts without reliance upon or reference to petitioner's alleged concession (R. 51-54).

3. The Court Is Incorrect in Treating Petitioner's Failure to Appeal From the Adverse Portions of the Examiner's Findings as a Waiver of Its Contentions.

The Examiner directed the complaint to be dismissed; his order was favorable to petitioner. The Commission's Rules of Practice are silent as to consequences of failure to appeal from adverse portions of favorable order (Slip Opinion, p. 6). In the absence of an explicit contrary provision in the Rules of Practice, petitioner should have been entitled to the benefit of the usual rule that a favorable decision below may be defended upon appeal upon any valid ground. *Jaffke* v. *Dunham*, 352 U.S. 280. In view of the ordinary rule, it would be a violation of the Administrative Procedure Act (Section 3(a), 5 U.S.C. 1002(a))[2] to require an appeal for the protection of petitioner's position in the absence of a published statement in the Commission's rules to that effect.

The Commission's requirement of waiving other defenses as a prerequisite to alleging abandonment put petitioner to the Hobson's choice of defending the Examiner's order on the Examiner's grounds or on the merits and on the Commission's earlier errors in excluding the trade practice evidence, but not on both. Under the Court's decision, if successful respondents before the Examiner in

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ance with the agreement, and may contain a statement that the signing of said agreement is for settlement purposes only and *does not constitute an admission by respondents that they have violated the law as alleged in the complaint.*" (Emphasis added.)

[2] "No person shall in any manner be required to resort to organization or procedure not so published."

abandonment cases cross-appeal to the Commission on the merits or on jurisdictional grounds, the result will be automatic reversal of the Examiner's findings of abandonment. *National Casualty Co., supra; Massachusetts Bonding and Insurance Company, supra.*

4. Petitioner Had No Opportunity Before the Commission to Object to Some of the Commission's Findings.

The Commission, in its final decision, made findings reversing findings of the Examiner on the merits favorable to petitioner on the issues of renewability of the policies and certain other matters relating to the lawfulness of petitioner's practices (R. 51-54). Petitioner never had an opportunity before the Commission to object to these findings.

CONCLUSION

For the reasons stated, it is respectfully submitted that the case should be reheard and the opinion and decision of the Court modified in accordance with the matters set forth herein.

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Attorneys for Petitioner

June 5, 1958

Certificate

I certify that this petition is submitted in good faith not for the purpose of delay, and that the matters of fact and law stated herein are believed by me to be meritorious.

A. Alvis Layne, Jr.

(Order Denying Petition of Petitioner for Rehearing.)

United States Court of Appeals
for the
Eighth Circuit

No. 1583 - - - September Term, 1957.
Friday, June 13, 1958.

Automobile Owners Safety Insurance Company,

Petitioner,

vs.

Federal Trade Commission.

Petition to Review Decision of the Federal Trade Commission.

Petition for rehearing filed by petitioner in this cause having been considered by this Court, It is now here Ordered that the same be, and it is hereby denied.

June 13, 1958.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 15830 September Term, 1957

Automobile Owners Safety Insurance Company,
Petitioner,

vs.

Federal Trade Commission,

Petition to Review Decision of the
Federal Trade Commission

On consideration of the motion of petitioner for stay of judgment and decree of enforcement in this cause pending petition to the Supreme Court of the United States for writ of certiorari, it is now hereby Ordered by this Court that the time in which to file report of compliance with Order to cease and desist dated April 26, 1957, which report is now due sixty days after July 3, 1958, be and the same is hereby extended for a period of thirty days and if within said period of thirty days there is filed with the Federal Trade Commission a certificate of the Clerk of the Supreme Court of the United States that a petition for writ of certiorari and record have been filed, the extension hereby granted shall continue to the final disposition of the case by the Supreme Court.

August 6, 1958

Attest:
Robert G. Tanner
Clerk, U.S. Court of Appeals
Eighth Circuit.